AAPC

# COPC®

Certified Ophthalmology Coder

# STUDY GUIDE



2026

2026

# Specialty Study Guide: COPC®

## OPHTHALMOLOGY



# Contents

# 2026 Specialty Study Guide: COPC® Introduction

*The Specialty Study Guide: Certified Ophthalmologic Coding Professional (COPC)* is designed to help ophthalmology coders, billers, and other medical office professionals prepare for the COPC® examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding ophthalmology services.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a COPC® shows your expertise in ophthalmology coding and also helps your employer. Membership in AAPC lends integrity to your credentials, provides a large network of coders for support, and allows you access to continuing education opportunities. The Specialty Study Guide: COPC® is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the COPC® examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT® as well as emphasize the importance of correct ophthalmology coding. You will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books. These are the books you will need for the study guide and the COPC® exam, as well.

## ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in future reimbursement. It is important to code correctly now.

We will discuss the major topics of diagnosis coding for evaluation and management. The examinee must become familiar with the ICD-10-CM Official Guidelines for Coding and Reporting. The successful examinee must know how to select the appropriate ICD-10-CM codes as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). This year's guidelines can be found at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-10-CM code book.

## Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices, and the evaluation and management (E/M) material will focus on the E/M services and underscore the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes is an important foundation for accurate code selection that is provided in your CPT® codebook.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

## CPT® Coding

Surgical procedures specific to ophthalmology are covered in this section. Special attention will be paid to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions are helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor intensive procedures. The codes with the highest RVUs (Relative Value Units) are sequenced first.

## Practice Exam

The practice exam and the exam itself were written by coders with extensive experience in ophthalmology. The practice exam mimics the format and structure of the COPC® certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective specialty disciplines. The following is some information on the COPC® credential:

- COPC® stands alone as a certification with no prerequisite that the examinee holds a CPC®, COC®, or CPB® credential.
- Exams aptly measure preparedness for real world coding by being entirely operative/patient-note based. These notes are redacted notes from real practices.

The COPC® examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you sit for this exam, remember that individual payer

rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that the patient is covered by Medicare, you should follow the CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Eye care related acronyms
- Medical physiology
- Diagnostic testing
- Incident-to guidelines
- HIPAA regulations
- ICD-10-CM coding
- E/M code selection using the AMA CPT® Guidelines
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures 10000 Series
  - 10000 Series
  - 60000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the code books is essential, as time is an important element in successfully completing the exam. You should approach the exam as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam within the Specialty Study Guide: COPC® course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

## Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam, because they allow you a glimpse into the minds of the test's creators.

Examinees that pass the COPC® certification examinations will receive recognition in AAPC's monthly magazine, Healthcare Business Monthly and receive a diploma suitable for framing.

## About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

## AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

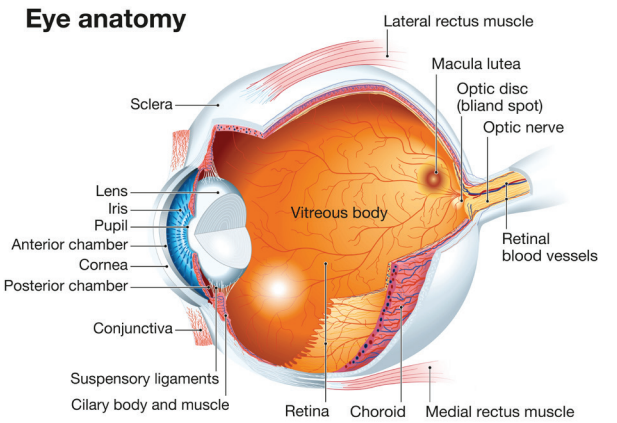
It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

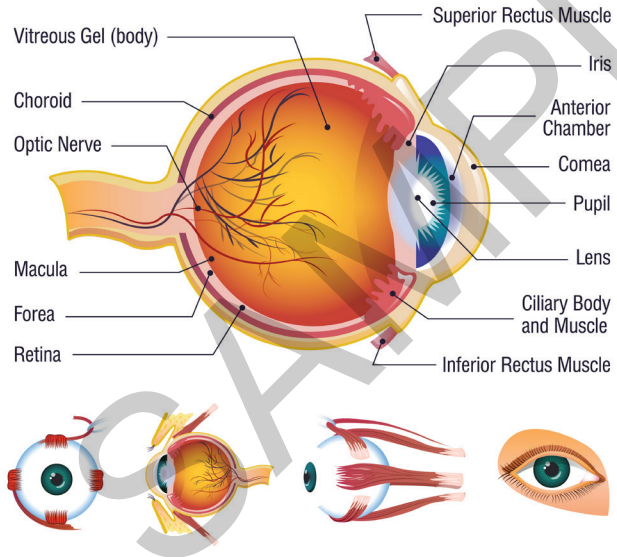
- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

## Overview

There are many diagnostic tests performed in ophthalmology and optometry practices; and, to code them to the correct levels you need to understand how the eye works. This chapter covers the anatomy and pathophysiology of the eye.




## Aqueous humor

Aqueous humors (AH) are fluid-like substances in the eye that give it shape. They also help to keep the eye healthy and functioning properly. Aqueous is a thin, watery fluid located in the anterior and posterior chambers of the eye. The anterior chamber lies between the iris, which is the colored part of the eye, and the inner surface of the cornea or the front of the eye. The posterior chamber is located behind the iris and in front of the lens. Aqueous humor is a vital intraocular fluid responsible for supplying nutrients to and removal of metabolic wastes from the avascular tissues of the eye. It is also necessary for the maintenance of the optical properties of the eye. The fluid dynamics of AH are frequently associated with glaucoma.

### Glaucoma

Glaucoma is classified as closed- or open-angle. Closed angle glaucoma often presents with acute symptoms such as eye pain and blurred vision and is considered an emergency. Primary open-angle glaucoma (POAG) is the more prevalent form of glaucoma and is a leading cause of impaired vision. It reduces the blood flow and damages the optic nerve and is considered the leading cause of irreversible blindness in the world. It also causes optic neuropathy, in which the axons of the optic nerve die. The condition is much rarer in those under 40 years-of-age and more common in those over 70 years-of-age.

The leading causes of risk include:

- Age
- Increased intraocular pressure (IOP)
- History of fracture
- Race
- Family history
- Diabetes
- Poor vision
- Certain medications

Studies show that the optic nerve gets damaged due to eye pressure. In the front of the eye is a space called the anterior chamber. There is a clear fluid that flows continuously in and out of the chamber and nourishes nearby tissues. The fluid leaves the chamber at the open angle where the cornea and iris meet. When the fluid reaches the angle, it flows through a sponge like meshwork that acts as a drain and leaves the eye.

In open angle glaucoma, even though the drainage angle is "open," the fluid passes too slowly through the drain and the fluids build up causing the pressure in the eyes to rise to a level that damages the optic nerve. Another risk factor for optic nerve damage relates to blood pressure. Not everyone who develops the increased eye pressure will develop glaucoma as each patient handles the pressure differently than others.

Primary open-angle glaucoma usually results from decreased outflow of aqueous fluid due to an acceleration and

exaggeration of normal aging changes in the anterior chamber angle, iris, and ciliary body tissues of the eye. It generally occurs bilaterally but it is not always symmetric in the stage.

Secondary open-angle glaucoma may result from a variety of substances that mechanically block the outflow of aqueous through the anterior chamber angle.

Glaucoma can develop without increased eye pressure. This is called low-tension or normal-tension glaucoma. It is a type of open-angle glaucoma. Les common causes of glaucoma include a blunt or chemical injury to the eye, severe eye infection, blockage of blood vessels in the eye, inflammatory conditions of the eye, and occasionally eye surgery to correct another condition. It can form in both eyes at different stages.

Closed-angle glaucoma is less frequent and poor drainage is caused because the angle between the iris and the cornea is too narrow and is physically blocked by the iris. This condition leads to a sudden buildup of pressure in the eye.

### Central Retinal Artery and Vein

The retina is supplied by the central retinal artery and the short posterior ciliary arteries. The central retinal artery travels in or beside the optic nerve as it pierces the sclera then branches to supply the layers of the inner retina. The arterial input to the eye is provided by several branches from the ophthalmic artery, which is derived from the internal carotid artery. These branches include the central retinal artery, the short and long posterior ciliary arteries, and the anterior ciliary arteries. Venous outflow from the eye is primarily via the vortex veins and the central retinal vein, which merge with the superior and inferior ophthalmic veins that drain into the cavernous sinus, the pterygoid venous plexus, and the facial vein. Patients who present with sudden, painless, severe vision loss usually suffer from an occlusion of the central retinal artery.

### Retinal Vein Occlusion

Retinal vein occlusion (RVO) is a common vascular disorder of the retina and one of the most common causes of vision loss worldwide. Retinal vein occlusion is a blockage of the small veins that carry blood away from the retina. The retina is the layer of tissue at the back of the inner eye that converts light images to nerve signals and sends them to the brain.

Retinal vein occlusion is most often caused by hardening of the arteries (atherosclerosis) and the formation of a blood clot. Blockage of smaller tributary veins (branch veins or BRVO) in the retina often occurs in places where retinal arteries that have been thickened or hardened by atherosclerosis cross over and place pressure on a retinal vein.

Risk factors for retinal vein occlusion include:

- Atherosclerosis
- Diabetes
- High blood pressure (hypertension)
- Other eye conditions, such as glaucoma, macular edema, or vitreous hemorrhage

The risk of these disorders increases with age, and retinal vein occlusion most often affects the elderly.

Symptoms include sudden blurring or vision loss in all or part of one eye.

RVO is classified where the occlusion is located. Occlusion of the central retinal vein at the level of the optic nerve is referred to as central retinal vein occlusion (CRVO). Occlusion at the primary superior branch or primary inferior branch involving approximately half of the retina is referred to as hemiretinal vein occlusion (HRVO). Obstruction at any more distal branch of the retinal vein is referred to as branch retinal vein occlusion (BRVO). The location of the occlusion influences the pathogenesis, clinical presentation, and management of RVO.

RVO is further subdivided into nonischemic and ischemic types, by the amount of retinal capillary ischemia seen by the ophthalmologist on fluorescein angiography.

## Choroid

The choroid of the eye is primarily a vascular structure supplying the outer retina. It contains large membrane-lined lacunae that function as part of the lymphatic drainage of the eye and which can change their volume dramatically. It has several functions such as the vasculature is the major supply for the outer retina; impairment of the flow of oxygen from choroid to retina may cause age-related macular degeneration (ARMD). The choroidal blood flow, which is as great as in any other organ, may also cool and warm the retina. In addition to its vascular functions, the choroid contains secretory cells, probably involved in modulation of vascularization and in growth of the sclera. The dramatic changes in choroidal thickness move the retina forward and back, bringing the photoreceptors into the plane of focus, a function demonstrated by the thinning of the choroid that occurs when the focal plane is moved back by the wearing of negative lenses, and, conversely, by the thickening that occurs when positive lenses are worn.

### Choroiditis

Choroiditis is an inflammation accompanied by swelling, where only the choroid alone (not the retina) is affected. The infection can be found in children and adults with immune deficiency. Usually the only symptom is blurred vision.

Multifocal choroiditis and panuveitis (MCP) is characterized by intraocular inflammation and multifocal choroidal lesions occurring in the absence of any known ocular or systemic

## Introduction to ICD-10-CM Coding Guidelines

Coders from all specialties need to have a full understanding of the ICD-10-CM coding guidelines. In ophthalmology, many of the services/procedures are tied to medical policy such as coverage determinations. Knowing the correct sequencing and assignment are crucial to avoid denials.

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the NCHS. Healthcare providers must begin using the most recent ICD-10-CM code revisions on Oct. 1 of each year, with no grace period to transition to the changes.

All versions of the ICD-10-CM code book typically include the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are an invaluable source for diagnosis coding information and provide instructions supplemental to that found in the Tabular List and the Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes are utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that claim (individual dates of service must stand alone), and coders must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as acute when it is not documented as such).

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses (diagnoses, in addition to the principal diagnosis, that affect the patient's care).
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These includes information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, and more.

## General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together to determine the diagnosis code. When attempting to select an ICD-10-CM diagnosis code, begin by searching for the main term—such as lesion, burn, etc.—in the Alphabetic Index. Follow all cross-references and "see also" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instructions. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. Generally, speaking, the first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding pre-existing conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit. Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis only when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th code character (which specifies location), a 6th code character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th code character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with your provider to ensure that the information necessary for proper coding is always noted.

# General ICD-10-CM Guidelines

## Signs/Symptoms and Confirmed/Unconfirmed Diagnoses

Use of codes that describe signs and symptoms are acceptable when the provider has not established a related, definitive diagnosis. Report only confirmed diagnoses. Uncertain diagnoses described as "probable," "possible," "suspected," "likely," "rule out," "consistent with," "compatible with," etc., are not coded. Code the highest level of certainty known, using codes that describe known signs, symptoms, abnormal test results, etc.

For example, if a patient has a breast mass and the provider suspects breast cancer, you should not report breast cancer as the diagnosis. Instead, report the signs and symptoms, such as breast mass, that prompted the exam. If testing later confirms cancer, only then should you report the cancer diagnosis.

For outpatient encounters diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, report any confirmed or definitive diagnosis(es) documented in the interpretation. If a definitive diagnosis is known, do not code related signs and symptoms as additional diagnoses. That is, if the test is positive, you report the findings. For tests interpreted as normal, code the condition, symptom, or sign that necessitated the diagnostic study.

In rare occurrences, a test is ordered without a clear indication of reason, and the ordering physician is not available to gather enough information prior to treating the patient. In such a case, you will want to confirm the order for the physician's reason(s) that the test was ordered.

When you are provided with both a preoperative and postoperative diagnosis, always report the *postoperative* diagnoses codes if the pre- and postoperative diagnoses differ.

Signs and symptoms attributable to a definitive diagnosis should not be reported separately. Cite additional signs and symptoms beyond the primary diagnosis only when those signs and symptoms are not integral to the disease process. Report only those additional conditions that affect treatment, and that the provider documents for the current visit.

Above all, do not extrapolate or assume information. Select codes only from what is apparent in the available documentation. Diagnosis codes should be used to the highest level of specificity, the use of unspecified codes should always be limited to when there is not enough information for the provider to assign a more appropriate code.

## Acute vs. Chronic

The doctor makes the determination as to when a condition becomes chronic. Coders will select an appropriate code for acute or sub-acute (primary) versus chronic (secondary) based on the available documentation.

If a patient's condition is described as being both acute/sub-acute and chronic, and a single code does not describe this combination, the ICD-10-CM code book provides instruction to report the acute (sub-acute) code as first-listed, with the chronic code secondary.

## Sequela (Late Effects)

Sequela (late effects) codes are usually reported as secondary diagnoses, with the effect or reason for the visit as primary. There is no time limit (such as 90 days, one year, etc.) in which late effects can occur.

Sequela (late effects) of cerebrovascular disease fall specifically to category I69, which indicate conditions classifiable to I60-I67 (hemorrhage, occlusion, and stenosis, etc.) as the cause of sequela (late effects). Guidelines indicate that the late effects include neurologic deficits caused by cerebrovascular disease and may be present from the onset or may arise at any time after the onset of the condition—classifiable to categories I60-I67. A code(s) from category I69 may be assigned on a health case record with codes from I60-I67 if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

Some of the codes in category I69 that specify hemiplegia, hemiparesis, and monoplegia also identify whether the dominant or nondominant side is affected. If the dominance is not stated (right-handed, left-handed, or ambidextrous), and the classification does not indicate a default, then the following applies:

- For ambidextrous patients, the default is always dominant.
- If the left side is affected, the default is nondominant.
- If the right side is affected, the default is dominant.

## Reporting a Single Condition with Multiple Codes

More than one ICD-10-CM code may be necessary to describe a single condition accurately. The ICD-10-CM code book uses notes, brackets, and italics to identify those situations. Be on the lookout for "code first," "use additional," "identify organism," and "in diseases classified elsewhere" notes in the text of ICD-10-CM. For example, when reporting osteoporosis (M80.-), the ICD-10-CM code book will instruct you to use additional code to identify major osseous defects, if applicable.

# Evaluation and Management Coding for Ophthalmology

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the COPC® exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

## An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

## Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT®

code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

## Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

### EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

| New Patient Code | Established Patient Code | Level of MDM |
|---|---|---|
| | 99211 | N/A<br><br>99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211. |
| 99202 | 99212 | Straightforward |
| 99203 | 99213 | Low |
| 99204 | 99214 | Moderate |
| 99205 | 99215 | High |

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

### Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

### TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

## National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUE)

CMS designed the NCCI "to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims," according to the agency's own introduction to NCCI. The NCCI lists thousands of "edits"—code combinations that you should not, in most circumstances, report together during the same patient encounter. You must apply these edits when reporting services to all Medicare (and many private) payers.

The NCCI divides its edits into two categories: mutually exclusive and "correct coding" edits. Mutually exclusive edits pair procedures or services the physician would not reasonably perform at the same session at the same anatomic location on the same beneficiary. Correct coding edits describe bundled procedures. That is, CMS considers one code in each pair to be a lesser service, which is included as a component of (and, not separately payable with) the more extensive procedure.

CMS guidelines allow you to override some NCCI edits and achieve separate reimbursement for bundled codes. Before attempting to unbundle an NCCI edit, however, you must determine two points:

- Is the override possible? Each NCCI code pair edit includes a correct coding modifier indicator of either 0 or 1. The correct coding modifier indicator is listed in the Modifier column of the NCCI spreadsheet. A "0" indicator means that you may not unbundle the edit combination under any circumstances, according to NCCI guidelines. An indicator of "1," however, means that you may use a modifier to override the edit if the two usually mutually exclusive or bundled procedures are separate and distinct from one another and the circumstances and documentation support the use of the modifier.
- Are the procedures truly distinct? You should only attempt to override NCCI code pair edits if the paired procedures are separate and unrelated. For instance, the physician may have provided the services/procedures at different sessions, at different anatomic locations, or for different diagnoses.

When unbundling NCCI edits, you must append modifier 59 to the column 2 code to indicate to the payer that the billed procedures are distinct and separately identifiable. The available documentation should support the use of modifier 59.

## Ophthalmology specific NCCI edits

- Codes 92002-92014 describe general ophthalmological services and cannot be reported with an E/M code. The E/M service includes the ophthalmological services.
- Special ophthalmologic services represent specific services not included in a general or routine ophthalmological examination. These special services are considered significant, separately identifiable services and may be reported separately.
- For procedures requiring intravenous injection of eye or other diagnostic agent, insertion of an intravenous catheter and dye injection are integral to the procedure and are not allowed to be reported separately. CPT® codes 36000 *Introduction of needle or intracatheter, vein* 36410 venipuncture, 96360-96368 IV vascular catherization codes are not reportable with the services that require intravenous injection (eg, 92230, 92235, 99240, 99242, 99287).
- 92230 and 92235 include selective catherization and injection procedures for angiography.
- 92250 *Fundus photography with interpretation and repor*t. There are limited instances when clinical conditions support them being reasonable and necessary on the ipsilateral eye. In those rare situations both codes may be reported using modifier 59 to code 92250.
- Posterior segment ophthalmic surgical procedures (67005-67229) include extended ophthalmoscopy (92201, 92202) if they are performed during the operative procedure or post-operatively on the same date of service. Unless it is performed on an emergency basis extended ophthalmoscopy is not normally performed per-operatively on the same date of service.
- 92071 *Fitting of contact lens for treatment of ocular surface disease* should not be reported with a corneal procedure CPT® code for bandage contact lenses applied after the completion of a procedure on the cornea.
- When a subconjunctival injection (for example, 68200) is performed as part of a more extensive anesthetic procedure, the subconjunctival injection is not separately reportable as it is considered part of the anesthetic procedure.
- Iridectomy and/or anterior vitrectomy may be performed in the conjunction with cataract extraction. If an iridectomy is performed to complete a cataract extraction, it is integral. A minimal vitreous loss

occurring during routine cataract extraction does not represent a vitrectomy and is not separately reportable. If an iridectomy or vitrectomy that is separate and distinct from the cataract extraction is performed for an unrelated reason at the same patient encounter, the iridectomy and/or vitrectomy may be reported separately with an NCCI-associated modifier. Medical record documentation must distinguish the medical necessity in support for each procedure. A trabeculectomy is separately reportable with cataract extraction. For example, if a patient with glaucoma requires a cataract extraction and a trabeculectomy is the appropriate treatment for the glaucoma, the trabeculectomy may be separately reportable. If the trabeculectomy as a preventive service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, it is not reportable separately.

- CPT® codes describing cataract extraction (66830-66988) are mutually exclusive of one another. Only one code per eye in this range may be reported.
- Any codes for retinal detachment are mutually exclusive and should not be reported separately for the ipsilateral eye on the same date of service. Some retinal detachment repair procedures include vitreous procedures which are not separately reportable. For example, 67108 includes 67105, 67025, 67028, 67031, 67036, 67039, and 67040.
- The procedures described in 68020-68200 for incision, drainage, biopsy, excision, or destruction of the conjunctiva are all included in all conjunctivoplasties. Codes 68020-68200 should not be reported separately with 68320-68362 for the ipsilateral eye.
- Code 67950 for canthoplasty is included in repair procedures such as blepharoplasties (for example, 69717, 67924, 67961, 67966).
- Correction of lid retraction represented by code 67911 includes a full thickness graft as part of the procedure. Do not report the correction and graft separately.
- If it is medically necessary and reasonable to inject anti-sclerosing agents at the same patient encounter as surgery to correct glaucoma, the injection is included in the glaucoma procedure; the J codes and codes representing the injection should not be coded additionally.
- Because a visual field examination (92081-92083) would be performed prior to scheduling a patient for a blepharoplasty (15820-15823) or blepharoptosis (67901-67908) procedure, the visual field examination CPT® codes should not be reported separately with the blephoraplasty or blepharoptosis procedure codes for the same date of service.
- Repair of retinal detachment or repair of complex retinal detachment includes removal of lens if performed. The codes for removal of the lens should not be reported.
- CMS payment policy does not allow payment separately for blepharoptosis and blepharoplasty on the ipsilateral upper eyelid.
- 65420 and 65426 describe the excision of the pterygium without and with graft respectively. Graft codes and the ocular surface reconstruction CPT® codes 65780-65782 should not be reported separately.
- Procedures of the cornea should not be reported with anterior chamber "separate procedures" such as 65800-65815 and 66020.

# Eyeball

## Removal of Eye 65091-65114

Procedures in this code range have medically unlikely edits of 1; if they are ever done bilaterally (which would be extremely rare), watch modifier usage per payer guidelines. For Medicare patients, you would use the modifier 50; other payer requirements may vary. Most codes have the concept of with or without, usually in reference to implants. For services and supplies related to the prosthetic eyes, check with payer specific allowances for HCPCS level II codes (For example, L8610, V2623-V2626, V2628, and V2629).

Codes 65091 and 65093 *Evisceration of ocular contents; with/without implant* includes all procedure codes associated with the evisceration such as keratectomy, conjunctivoplasty, and sclerectomy. If scleral buckling material is removed from the outside of the globe during the evisceration procedure, use code 67120. Use code 65093 only if the initial implant is permanent. For delayed placement of the permanent artificial eye look at code 65130.

Code 65101 *Enucleation of eye; without implant, muscles not attached to implant* is for a technique that is rarely used, typically only in severe trauma cases. Caution should be used to make sure that work done represents the code(s) chosen. Perform careful review of documentation. Rearrangement of conjunctival tissues following enucleation and placement of an artificial eye can be separately reported (68320-68340).

Code 65110 describes exenteration of orbit, removal of orbital contents only. Orbital exenteration typically involves removal of the entire contents of the orbit including the periorbita, appendages, eyelids and, sometimes, a varying amount of surrounding skin.

- For skin graft to orbit (split skin) see 15120 and 15121.
- For free, full-thickness, see 15260, 15261.
- For eyelid repair involving more than skin, see 67930.
- If orbital bone is removed, use 65112 instead of 65110.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the test your knowledge practice exams.

## Version A

### CASE 1

History

Reason for Visit Est. E/M

Pt wears specs. NOT COMP. PT IS HERE FOR DFE, OCT, M2 VF, PHOTOS.

**PLAQUENIL:** Still taking medication. Fundus photos: Done today, OU. Ocular HX: ERM: OD -Pt is in for DFE, OCT Macula, Macular VF screening and photos today.

**Patient Reason:** Provider Reason: cc ERM OU, and Plaquenil exam... no noticeable changes seeing Dr. Apple next week for eval

History of Present Illnesses High Risk Medication Location: Quality: Severity: Duration: Timing: Context: Mod Factors: Assoc Signs: Mild - Ongoing Condition - Associated with medical condition - Treated by another provider Printed On: 01/13/2017 Review of Systems all negative. These included: Ocular: Constitution ENT: Neuro: Cardio: Respiratory: Psych: GI: GU: Musc/Skel: Integ: Hem/Lymph Allergy/Im Endo: Negative Hypertension Anemia Environmental Allergies, Rheumatoid Arthritis

Current Medications Plaquenil 200 MG Oral Tablet High Blood Pressure Medication Arthritis Medication No latex sensitivity

**Social History Tobacco:** none Alcohol: socially

**Family History:** Diabetes mellitus and thyroid disorder.

**DPA:** Paremyd

Aided Visual Acuity:

OD Distance VA (20/) 25

OD Distance VA Modifier -1 OU

Distance VA (20/) 20 OU Near VA (20/) 30

VA Method Snellen

OS Distance VA (20/) 25

OS Distance VA Modifier

OU Distance VA Modifier -2

Rx Worn Habitual Glasses

IOP

OD 21

OS 20

Adnexa OD NL

Anterior Chamber OD Deep & Quiet

Bulb Conj OD Clear

Cornea OD Clear

Episclera OD Clear OD

Iris Flat and Clear OD

Lens Clear OD

Palpebral Conjunctiva OD Clear

Sclera OD Clear

Adnexa OS NL

Anterior Chamber OS Deep & Quiet

Bulb Conj OS Clear

Cornea OS Clear

Episclera OS Clear

OS Iris Flat and Clear

OS Lens Clear

Palpebral Conjunctiva OS Clear

Sclera OS Clear

OCT retina performed today and remains stable when compared to previous testing one year ago

Final Refraction
OD -0.25 -1.50 x 085

Assessment and Plan:

Myopia, bilateral

Regular astigmatism, bilateral

Other long term (current) drug therapy for RA

## CASE 1

History

Reason for Visit Est. E/M [1]

Pt wears specs. NOT COMP. PT IS HERE FOR DFE, OCT, M2 VF, PHOTOS.

**Plaquenil:** Still taking medication. Fundus photos: Done today, OU. Ocular HX: ERM: OD -Pt is in for DFE, OCT Macula, Macular VF screening and photos today.

**Patient Reason:** Provider Reason: cc ERM OU, and Plaquenil exam... no noticeable changes seeing Dr. Apple next week for eval

History of Present Illnesses High Risk Medication Location: Quality: Severity: Duration: Timing: Context: Mod Factors: Assoc Signs: Mild - Ongoing Condition - Associated with medical condition - Treated by another provider Printed On: 01/13/2017 Review of Systems all negative. These included: Ocular: Constitution ENT: Neuro: Cardio: Respiratory: Psych: GI: GU: Musc/Skel: Integ: Hem/Lymph Allergy/Im Endo: Negative Hypertension Anemia Environmental Allergies, Rheumatoid Arthritis

Current Medications Plaquenil 200 MG Oral Tablet High Blood Pressure Medication Arthritis Medication No latex sensitivity

**Social History Tobacco:** none Alcohol: socially

**Family History:** Diabetes mellitus and thyroid disorder.

**DPA:** Paremyd

Aided Visual Acuity:

OD Distance VA (20/) 25

OD Distance VA Modifier -1 OU

Distance VA (20/) 20 OU Near VA (20/) 30

VA Method Snellen

OS Distance VA (20/) 25

OS Distance VA Modifier

OU Distance VA Modifier -2

Rx Worn Habitual Glasses

IOP

OD 21

OS 20

Adnexa OD NL

Anterior Chamber OD Deep & Quiet

Bulb Conj OD Clear

Cornea OD Clear

Episclera OD Clear OD

Iris Flat and Clear OD

Lens Clear OD

Palpebral Conjunctiva OD Clear

Sclera OD Clear

Adnexa OS NL

Anterior Chamber OS Deep & Quiet

Bulb Conj OS Clear

Cornea OS Clear

Episclera OS Clear

OS Iris Flat and Clear

OS Lens Clear

Palpebral Conjunctiva OS Clear

Sclera OS Clear

OCT retina performed today and remains stable when compared to previous testing one year ago

Final Refraction

OD -0.25 -1.50 x 085

Assessment and Plan:

Myopia, bilateral [2]

Regular astigmatism, bilateral [2]

Other long term (current) drug therapy for RA

[1] Established patient

[2] Two stable chronic conditions

1. **Answer:** A. 99213, 92015, 92134

   **Rationale:** The E/M level of service is 99213 (Moderate level for number/complexity of problems addressed, None for amount/complexity of data, and Low level of risk). Code 92015 is supported with documentation of the final refraction. The interpretation for the OCT indicates the diagnostic test was performed and interpreted. Code 92134 is specific to the retina.

# Join the biggest team in healthcare information management.

As an AAPC member, you'll be part of a global network of 250,000+ career learners and working professionals. Our credentials are among the most highly sought after in the industry — in part because AAPC members are trained for more than passing an exam. They are trained to succeed on the job from day one.

*"If you want to rise in the ranks of the Healthcare business portion of the medical field, I highly suggest that you become a member of AAPC and obtain your certifications through them. They will help you to advance and open the door of opportunity for you."*

**- Latisha Booker, CPC**

*"APPC has not only provided me with the opportunity to earn multiple credentials but has also opened important doors for me in my career."*

**- Mary Arnold, CPC, CPMA, CRC, RMA, HR-C**

*"While taking classes, I was introduced to AAPC. I became a member to help boost my career, and more than 20 years later, I'm still an AAPC member."*

**– Bradley Miller, CPC, CRC, CDEO**

Whether you're just getting started or a seasoned pro, AAPC membership will give you the support, training, tools, and resources to help you launch and advance your career successfully,



Learn more at **aapc.com**

AAPC