

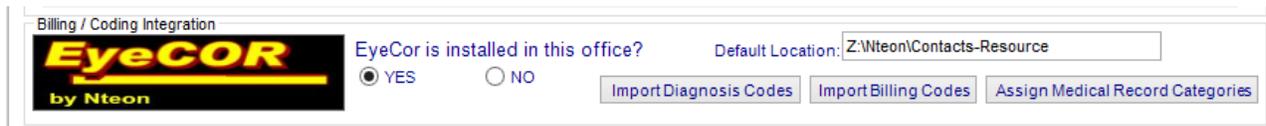
## Integrating EyeCor with Crystal

Go to Admin > Integrations.

Where it asks “EyeCor is installed in this office?” click “YES”.

Set the default location of the program.

(To find the default location, right click on the desktop icon and select “Open File Location”)



Billing / Coding Integration

**EyeCOR**  
by Nteon

EyeCor is installed in this office?  
 YES  NO

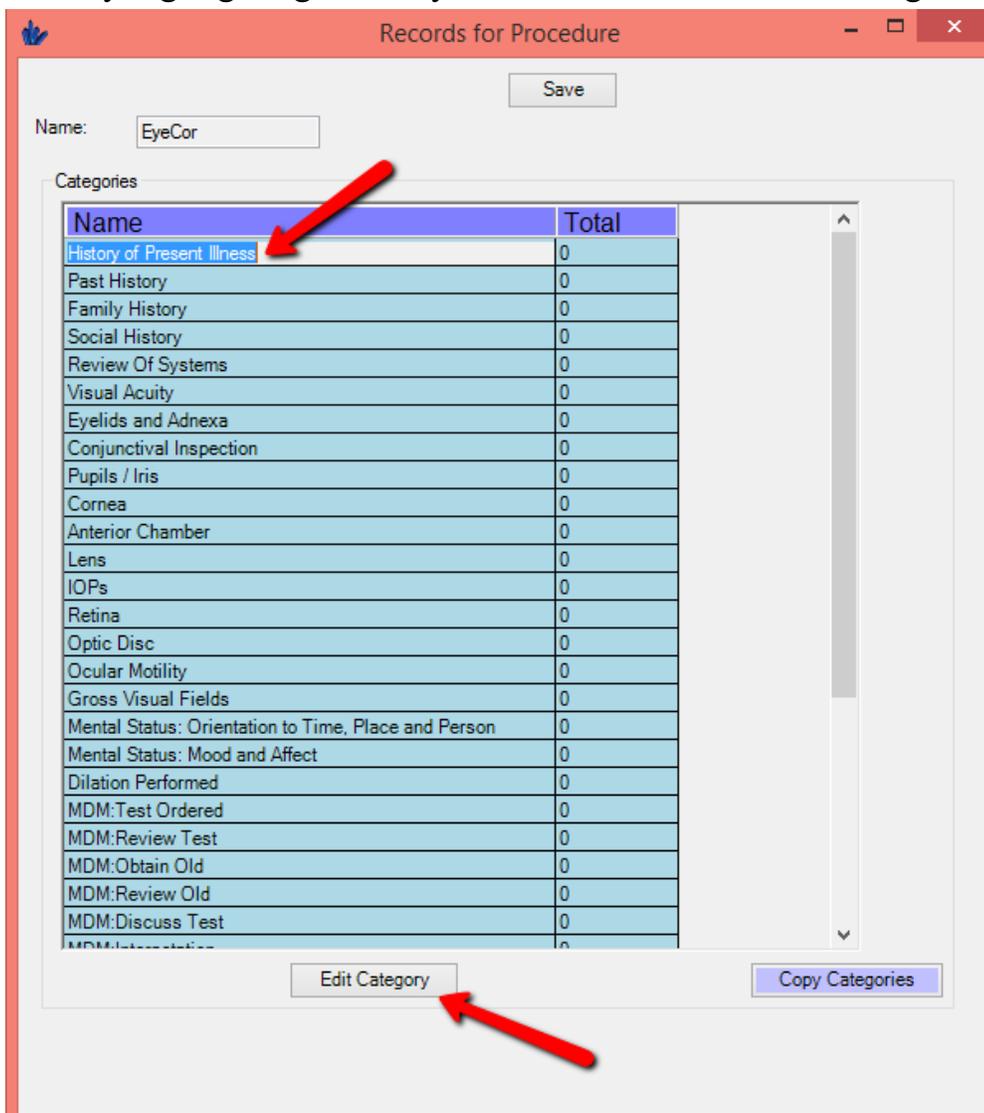
Default Location: Z:\Nteon\Contacts-Resource

Import Diagnosis Codes Import Billing Codes Assign Medical Record Categories

Next, click on “Assign Medical Record Categories”.

Here is where you will assign your template fields to the required categories.

Start by highlighting “History of Present Illness” and clicking “Edit Category”.



Records for Procedure

Save

Name: EyeCor

Categories

| Name   | Total |
|--|-------|
| History of Present Illness                           | 0     |
| Past History   | 0     |
| Family History                                       | 0     |
| Social History                                       | 0     |
| Review Of Systems                                    | 0     |
| Visual Acuity  | 0     |
| Eyelids and Adnexa                                   | 0     |
| Conjunctival Inspection                              | 0     |
| Pupils / Iris  | 0     |
| Cornea   | 0     |
| Anterior Chamber                                     | 0     |
| Lens   | 0     |
| IOPs   | 0     |
| Retina   | 0     |
| Optic Disc   | 0     |
| Ocular Motility                                      | 0     |
| Gross Visual Fields                                  | 0     |
| Mental Status: Orientation to Time, Place and Person | 0     |
| Mental Status: Mood and Affect                       | 0     |
| Dilation Performed                                   | 0     |
| MDM:Test Ordered                                     | 0     |
| MDM:Review Test                                      | 0     |
| MDM:Obtain Old                                       | 0     |
| MDM:Review Old                                       | 0     |
| MDM:Discuss Test                                     | 0     |
| MDM:Investigate                                      | 0     |

Edit Category Copy Categories

Here you will see each template tab from your medical records along with every field in each tab. Check the fields that correspond with HPI and click “Save Category”.  
(Please note that the tabs below may not match your tabs as you may be using a completely different template.)

The screenshot shows a software window titled "Records for Procedure". At the top, there is a "Save" button and a "Name:" field containing "EyeCor". Below this is a "Category Name:" field containing "History of Present Illness". A row of tabs is visible, including "Subj", "Ant/Post", "Drug", "CL Fit", "CL Eval", "A & P", "Final Rx", "Office Visit", "Post-Op", and "Glu". The main area is a table with three columns: "Field ID", "Name", and "Include within Category". The row for "1292 HX of PRESENT COMPLAINT" is highlighted with a red box, and its checkbox is checked. A red arrow points to the "Save Category" button at the bottom of the table.

| Field ID | Name                    | Include within Category             |
|----------|-------------------------|-------------------------------------|
| 1291     | CHIEF COMPLAINT         | <input type="checkbox"/>            |
| 1294     | VA OD sc 20/            | <input type="checkbox"/>            |
| 2173     | VA OD cc 20/            | <input type="checkbox"/>            |
| 1295     | VA OS sc 20/            | <input type="checkbox"/>            |
| 2174     | VA OS cc 20/            | <input type="checkbox"/>            |
| 2186     | GI                      | <input type="checkbox"/>            |
| 1298     | VA PH OD 20/            | <input type="checkbox"/>            |
| 2187     | CL                      | <input type="checkbox"/>            |
| 1299     | VA PH OS 20/            | <input type="checkbox"/>            |
| 1292     | HX of PRESENT COMPLAINT | <input checked="" type="checkbox"/> |
| 3166     | Timing                  | <input type="checkbox"/>            |
| 3161     | Quality                 | <input type="checkbox"/>            |
| 3167     | Context                 | <input type="checkbox"/>            |
| 3163     | Severity                | <input type="checkbox"/>            |
| 3168     | Duration                | <input type="checkbox"/>            |
| 3164     | Modifying               | <input type="checkbox"/>            |
| 3169     | Associated Signs        | <input type="checkbox"/>            |
| 1296     | VA OD Habitual 20/      | <input type="checkbox"/>            |
| 1297     | VA OS Habitual 20/      | <input type="checkbox"/>            |
| 1293     | EYE MEDS                | <input type="checkbox"/>            |
| 1302     | PUPILS                  | <input type="checkbox"/>            |
| 2161     | EOM                     | <input type="checkbox"/>            |
| 1303     | Drops                   | <input type="checkbox"/>            |

You will see your total under “History of Present Illness” has now changed from 0 to 1.

Do this for each Category listed.

**When completed, click SAVE at the top and close out.**

**\*\*\*For more in depth linking instructions, [click here](#).**

Now you need to create an EyeCOR button in your medical record.  
Go to Records > EHR Settings > Edit Med Records.

Click on **Add New Field**.

- Under the “Type” dropdown, choose “Button”.
- Enter “EyeCOR” in the Text Field
- Select the “Command” radio button.
- Select the “Pre-Loaded Application” radio button and choose “EyeCOR” from the list.

The screenshot shows the 'Edit Records' window. On the left is a table with columns 'FID', 'Text', 'Lines', and 'Description'. The table lists various fields, with the last row (FID 3342) being 'EyeCOR' of type 'Button'. On the right is a configuration panel for the selected field. The 'Text' field contains 'EyeCOR'. The 'Type' dropdown is set to 'Button'. The 'Description' field is empty. Under 'F9 Keys', there is a 'Button Settings' table with columns 'Fields', 'Type', and 'Action'. Below this are buttons for 'Add Command', 'Export', 'Import', and 'Remove Command'. There are three radio buttons: 'Field Action', 'Command' (selected), and 'If...Then...'. Under the 'Command' radio button, there are two options: 'Command Line' (unselected) and 'Pre-Loaded Application' (selected). The 'Pre-Loaded Application' dropdown is set to 'EyeCor'. At the bottom of the window, there are buttons for 'Add New Field' (highlighted with a red box), 'Delete Field', and a checked 'Edit Field' checkbox.

| FID  | Text                     | Lines    | Description |
|------|--------------------------|----------|-------------|
| -104 |                          | Diag ... | Diag Code 5 |
| -105 |                          | Diag ... | Diag Desc 5 |
| -106 |                          | Diag ... | Diag Code 6 |
| -107 |                          | Diag ... | Diag Desc 6 |
| -108 |                          | Diag ... | Diag Code 7 |
| -109 |                          | Diag ... | Diag Desc 7 |
| -110 | # Linked Images          | Num...   |             |
| -111 | Imaging Orders (non-R... | Num...   |             |
| -112 | Alerts                   | Button   |             |
| -113 | Tasks                    | Button   |             |
| -114 | Appts                    | Button   |             |
| -115 | RX His                   | Button   |             |
| -116 | Billing Modifiers        | CPT ...  |             |
| -117 | Description              | CPT ...  |             |
| -118 |                          | CPT ...  |             |
| -119 |                          | CPT ...  |             |
| -120 |                          | CPT ...  |             |
| -121 |                          | CPT ...  |             |
| -122 |                          | CPT ...  |             |
| -123 |                          | CPT ...  |             |
| -124 | Proc His                 | Button   |             |
| -125 | Observstion His          | Button   |             |
| -126 | Drug His                 | Button   |             |
| -127 | Diag His                 | Button   |             |
| 3342 | EyeCOR                   | Button   |             |

Minimize this Edit Records box.

Go to the tab where you want your buttons placed and right click where you want them and click “Add Field to Tab”.

You now have a button that will send your data to EyeCOR.

The setup is now completed.

Now, at the bottom of your Medical Record, select EyeCOR from the dropdown. This will highlight (shown below in blue) all field that must be completed to submit to EyeCOR (like a cheat sheet).

The screenshot shows a medical record form with various sections highlighted in blue. The highlighted sections are:

- CHIEF COMPLAINT
- HPI (Location, Quality, Timing, Context)
- PATIENT OCULAR HISTORY (Review of system)
- PATIENT MEDICAL HISTORY: HAs, Arthritis, Asthma, Diabetes, HBP, Heart, Infl. Bowel Dz, Seizures, Thyroid
- Drug Allergies
- Medications
- Injuries, Surgeries, Hospitalizations
- Other Notes From Patient
- FAMILY MEDICAL HISTORY
- SOCIAL HISTORY
- REVIEW OF SYSTEMS: GENERAL, INTEGUMENTARY, NEUROLOGICAL

At the bottom of the form, a dropdown menu is set to "EyeCor".

**ADDITIONAL FIELD LINKING INSTRUCTIONS:**

In EyeCor, click on Medical Coding and Reimbursement.



Click on Exam Adviser.



Single click on any CPT line to open up the screen shown below.

| CMS (HCFA) Coding Requirements |                             |                                |                   |   |                                       |                          |              |                     |
|--------------------------------|-----------------------------|--------------------------------|-------------------|---|---------------------------------------|--------------------------|--------------|---------------------|
| Code                           | History                     |                                |                   | Examination   | Medical Decision Making               |                          |              | Time (Face To Face) |
|                                | HPI History Present Illness | Personal Family Social History | Review Of Systems | Examination Elements                                | Amount or Complexity of Data Reviewed | Diagnosis and Management | Patient Risk |                     |
| 99211                          | 0                           | 0                              | 0                 | 0   | 0                                     | Minimal                  | None         | 5                   |
| 99212                          | 1 - 3                       | 0                              | 0                 | 1 - 5   | 1                                     | Minimal                  | Minimal      | 10                  |
| 99213                          | 1 - 3                       | 0                              | 1                 | 6 - 8   | 2                                     | Limited                  | Low          | 15                  |
| 99214                          | 4 +                         | 1                              | 2 - 9             | 9 - 13  | 3                                     | Multiple                 | Moderate     | 25                  |
| 99215                          | 4 +                         | 3                              | 10 +              | 14  | 4 +                                   | Extensive                | High         | 40                  |
| All three elements must be met |                             |                                | Required element  | Two of the Three elements must be met or exceeded * |                                       |                          |              |                     |

Click on **HPI History Present Illness**.

**History of Present Illness [HPI]**

History of Present Illness (HPI) is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. Alternatively, you can record the status of at least three chronic or inactive conditions.

**Record HPI with the following elements:**

- Location (Which eye or eye segment AND Condition - Eye Pain, Dry Eye or Diagnosis - Glaucoma, Cataract )
- Quality (Ache, Irritation)
- Severity (Severity of Condition or Diagnosis)
- Duration (Started 3 days ago)
- Timing (Continuous, Comes and Goes)
- Context (Cause)
- Modifying Factors (Cold Compress helps)
- Associated Signs Or Symptoms (Blurred vision)

**Examples: (Examples 1 & 2 show 4 elements for Extended HPI. )**

**Example 1 (Condition easily described by Patient:**  
 Bilateral Floaters (Location) Affects Vision (Quality) Started 1 year ago (Duration) Occurs Daily (Timing)

**Example 2 (Diagnosis NOT easily described by Patient:**  
 Bilateral Glaucoma (Location) Increased Optic Nerve Head (Severity) Diagnosed 6 months (Duration) Continuous (Timing)

**Example 3 (Record alternative of the status of at least three chronic or inactive conditions. Extended HPI)**  
 Current Glaucoma, Macula Puckering History of Dry Eye

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**Brief HPI:** Medical Record contains 1 - 3 elements of HPI

**Extended HPI:** Medical Record contains 4 or more elements of HPI  
 OR the status of at least three chronic or inactive conditions.

This shows all of the elements that should be linked to your template.

You must link the field/box/button for location, quality, severity, duration, timing, context, modifying factors, and associated signs or symptoms.

A brief HPI will contain 1-3 elements of HPI and an extended HPI will contain 4 or more. Close out this box.

Click on **Personal Family Social History**.

**Patient's Past, Family and Social History [PFSH]**

**PFSH consists of reviewing and documenting:**

**Past History:**  
Patient's past history with Illnesses, Operations, Injuries and Treatments.

**Family History:**  
Patient's Family medical events, including diseases which may be heredity or place patient at risk.

**Social History:**  
Age appropriate review of past and current activities.

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**Pertinent PFSH:** At least 1 item from any of the three history areas.

**Complete PFSH:** At least 1 item from EACH of the three history areas.

You will need to link your fields for past history, family history, and social history as described above.

Close out this box.

Click on **Review of Systems**.

## Review of Systems

Print

### Definition of Systems

|                          |                                  |
|--------------------------|----------------------------------|
| Constitutional           | (Fever, Weight Loss, etc.)       |
| Eyes                     |                                  |
| Ear, Nose, Mouth, Throat |                                  |
| Cardiovascular           |                                  |
| Respiratory              |                                  |
| Gastrointestinal         |                                  |
| Gentitourinary           | (Genital and Urinary Organs)     |
| Musculoskeletal          |                                  |
| Integumentary            | (Skin and/or Breast)             |
| Neurological             |                                  |
| Psychiatric              |                                  |
| Endocrine                | (Diabetes, Thyroid, Renal, etc.) |
| Hematologic Lymphatic    |                                  |
| Allergic Immunologic     |                                  |

### Problem Pertinent ROS - Established Patient Level 3 - New Patient Level 2

1 - Record Patient's Positive and Pertinent Negative Responses for System Related to Problem.

### Extended ROS - Established Patient Level 4 - New Patient Level 3

2 - 9 - Record Patient's Positive and Pertinent Negative Responses for the System Related to Problem and Additional Systems 2 - 9 systems should be documented.

### Complete ROS - Established Patient Level 5 - New Patient Level 4 & 5

14 - Record Patient's Positive and Pertinent Negative Responses for the System Related to Problem and All Additional Systems should be documented.

Close

Each of the item listed under Definition of Systems should be linked to a unique field in Crystal. If you do not have a field/box to capture this information, it must be added and linked.

See above the number of ROS to be recorded to satisfy a level 3, level 4, or level 5 coding. Close this box.

Click on **Examination Elements**.

## Elements of Examination

Print

### Record the following elements of the Eye Examination:

- Test visual acuity (Does not include determination of refractive error)
- Gross visual field testing by confrontation
- Test ocular motility including primary gaze alignment
- Inspection of bulbar and palpebral conjunctivae
- Ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands and drainage, orbits & preauricular lymph nodes
- Pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology
- Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film
- Slit lamp examination of the anterior chambers including depth, cells, and flare
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus
- Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)

Ophthalmoscopic examination through dilated pupils (unless contraindicated) of:

- Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer
- Posterior segments including retina and vessels (eg, exudates and hemorrhages)

Neurological / Psychiatric Brief Assessment of Mental Status

- Orientation to time, place and person
- Mood and Affect (depression, anxiety, agitation)

### Level of Examination

**Problem Focused:** 1 - 5 Elements listed above

**Expanded Problem Focused:** 6 - 8 Elements listed above

**Detailed:** 9 - 13 Elements listed above

**Comprehensive:** All 14 Elements listed above

Close

This lists each element of the eye that must be linked.

Click on **Amount of Complexity of Data Reviewed**.

## Amount and Complexity of Documentation

Print

### Documentation Guidelines:

- 1 - If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray should be documented.
- 2 - The review of lab, radiology and/or other diagnostic test should be documented. A simple notation such as 'WBC elevated' or 'chest x-ray unremarkable' is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.
- 3 - A decision to obtain old records or decision to obtain additional history from the family, caretaker, or other source to supplement that obtained by the patient should be documented.
- 4 - Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker, or other source of supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of 'old records reviewed' or 'additional history obtained from the family' without elaboration is insufficient.
- 5 - The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the laboratory, radiology or other diagnostic study should be documented.
- 6 - The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.

**Minimal or None:** 1 of the Documentation Guidelines completed.

**Limited:** 2 of the Documentation Guidelines completed.

**Moderate:** 3 of the Documentation Guidelines completed.

**Extensive:** 4 or more of the Documentation Guidelines completed.

Close

Click on **Diagnosis and Management**.

**Number of Diagnosis and Management Options** Print

**Number of Diagnosis and Management Options is the only E/M area where CMS does NOT define quantifiable targets. The process of documenting is defined and shown below. But there is no CMS definition on how to count the Options. There are some documents that show a point system for the items. However, these are NOT established or recognized by CMS.**

The number of possible diagnoses and/or the number of management options that must be considered is based on:

- The number and types of problems addressed during the encounter.
- The complexity of establishing a diagnosis and
- The management decisions that are made by the physician.

For each encounter, an assessment, clinical impression or diagnosis should be documented.

For a presenting problem with an established diagnosis:  
Record should reflect whether the problem is:

- a) improved, well controlled, resolving or resolved; or
- b) inadequately controlled, worsening, or failing to changes as expected.

For a presenting problem without an established diagnosis:  
Assessment or clinical impression may be stated in the form of differential diagnoses or as a 'possible', 'probable', or 'Rule Out' diagnosis.

The initiation of or change in treatment should be documented. Treatment includes wide range of management options including; Patient Instructions, Medications, Therapies etc.

If referrals are made, consultations requested or advice sought, the record should indicate whom or where the referral/consultation /advice is made or requested.

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**Minimal:**  
**Limited:**  
**Multiple:**  
**Extensive:**

Click on **Patient Risk**.

**Patient Risk** Print

| Risk Level | Patient Type |          | Presenting Problems  | Management Options Selected  |
|------------|--------------|----------|--|--|
|            | New          | Existing |  |  |
| Minimum    | 1 + 2        | 2        | One self-limited or minor problem  | -Rest<br>-Elastic bandages or Superficial dressings  |
| Low        | 3            | 3        | -Two self-limited or minor problems<br>-One stable chronic illness, eg, Glaucoma<br>-Acute uncomplicated illness or injury   | -Over-the-counter drugs<br>-Minor surgery with no identified risk factors  |
| Moderate   | 4            | 4        | -One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment<br>-Two or more stable chronic illnesses.<br>-Undiagnosed new problem with uncertain prognosis.<br>-Acute illness with systemic symptoms.<br>-Acute complicated injury.   | -Prescription drug management.<br>-Therapeutic nuclear medicine.<br>-Minor surgery w/ identified risk factors<br>-Elective major surgery no identified risk factors. |
| High       | 5            | 5        | -One or more chronic illnesses w/ severe exacerbation, progression, or side effects of treatment.<br>-Acute or chronic illnesses or injuries that pose a threat to life or bodily function.<br>-Abrupt change in neurological status, eg seizure or sensory loss.<br>-One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment. | -Elective major surgery with identified risk factors<br>-Emergency major surgery.<br>-Drug therapy requiring intensive monitoring for toxicity.                      |

This shows you how to determine an accurate rating on patient risk from risk level “minimum” to “high”.