PROVIDER ADMINISTRATIVE POLICY

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BENEFIT	**EYE CARE**	**POLICY SECTION**	**100 ADMINISTRATIVE**		**POLICY NO**	**100.01**	
POLICY TITLE	**OFFICE VISITS – Routine, Medical and Evaluation & Management Coding**						
POLICY DATE	**01/01/2022**	**REVISION DATE**	**08/08/2022**	**APPROVAL DATE**	**08/10/2022**		
DISCLAIMER LANGUAGE	- **Policies may be state specific or National version, see 'Applicable State'** - **Health Plan specific 'Indications and Limitations of Coverage' may apply as specified** - **Line of Business considerations (i.e., Medicaid, Medicare, Commercial) may apply as specified**						
EXCLUSIONS	- **DE, GA, NC, and TX:** **Table 1 in Section III.B: does not apply as S-codes are utilized for routine exams**						

I. POLICY STATEMENT

Avēsis will provide reimbursement of routine medical and specialty evaluation and management initial and subsequent office visits/examinations when core components and/or intensity of services applicable to selected code is supported by provider documentation in accordance with specified requirements. Requirements set forth are determined by the American Medical Association (AMA), specific state coverage requirements and/or national or local coverage determinations (NCD/LCD). Avēsis Medical Directors are licensed medical professionals and review criteria and documentation submitted by requesting providers against Avēsis criteria using sound medical judgment.

II. INDICATIONS AND LIMITATION OF COVERAGE

1.0 Medical documentation for routine eye or evaluation and management 'E&M' CPT code selected by the provider for submitted claims must be sufficiently detailed per requirements outlined below to support reimbursement.

- 1.1 Insufficient documentation or missing components in documentation submitted will result in denial of claim.
- 1.2 Requirements are inclusive of AMA, state requirements, and NCD/LCD, as applicable.

2.0 It is the responsibility of the provider to ensure enrollee is eligible for coverage for all dates of service.

- 2.1 Services provided for enrollee deemed ineligible for coverage will result in denial.

3.0 It is the responsibility of the provider to know and understand applicable compliance and rules specific to coding and requirements for appropriate medical documentation.

III. DOCUMENTATION REQUIREMENTS - GENERAL OPHTHAMOLOGICAL SERVICES and E&M EXAMINATION

A. <u>Overarching Requirements</u>

1.0 All required criterion components must be clearly and legibly documented in the patient's medical record and made available to Avēsis upon request.

2.0 Physician signature must be present on chart note, procedure note, orders, and testing interpretation.

3.0 Exam must be performed in accordance with professional standard practices of optometry and ophthalmology.

4.0 Tables 1 and 2 outline specific requirements dependent on coding selected and submitted by provider.

[1]American Academy of Ophthalmology https://www.aao.org

B. Routine Comprehensive Ophthalmological Examinations

Table 1

APPLICABLE CPT Code	Patient Status	Exam Intensity
92002	New	Intermediate (Comprehensive in NE)
92012	Established	Intermediate (Comprehensive in NE)
92004	New	Comprehensive (not available as routine in NE)
92014	Established	Comprehensive (not available as routine in NE)

Both Intermediate and Comprehensive Examinations must include all of the following requirements:

- *Medical/Eye History*

1.0 Chief Complaint 'CC'
  1.1 Any significant visual changes or complaints
2.0 History of Present Illness 'HPI'
  2.1 Location of chief complaint with duration
3.0 Current Medications
4.0 Family/Social History

- *Examination Components:*

5.0 Presenting visual acuity
  5.1 With or without correction
  5.2 Distance and near
6.0 Extra-Ocular Muscle (EOM) assessment
  6.1 Cover test
    6.1.1 Recorded at 16 inches
    6.1.2 Recorded at 20 feet
  6.2 Near point of convergence
  6.3 Versions
7.0 Gross Visual Field assessment
  7.1 List/Draw screening results
  7.2 Method (confrontation is sufficient unless defect is detected)
8.0 Refraction (Manifest)
  8.1 Objective refraction with visual acuity
  8.2 Subjective refraction must include best corrected visual acuity at distance and near
9.0 Adnexa/External
  9.1 Lids, lashes
  9.2 PALN (pre-auricular lymph nodes-if indicated)
10.0 Slit lamp exam of Anterior Segment must include:
  10.1 Cornea
  10.2 Conjunctiva
11.0 Slit lamp exam of Anterior Chamber
  11.1 Depth
  11.2 Clarity, presence of cell/flare
  11.3 Brief angle assessment prior to dilation

12.0 Slit lamp exam of Lens
- 12.1 Cataract findings must be graded
- 12.2 Media clarity

13.0 Tonometry (unless contraindicated or in child)
- 13.1 Method and Time notation
- 13.2 IOP

14.0 Pupillary Assessment (prior to dilation)
- 14.1 Size
- 14.2 Reaction
- 14.3 APD (presence or absence)

15.0 Posterior Segment Ophthalmoscopy (direct/indirect) of optic nerve must note:
- 15.1 Time of dilation unless contraindicated
- 15.2 C/D ratio
- 15.3 Appearance of nerve
- 15.4 Nerve Fiber Layer appearance
- 15.5 Posterior Segment Ophthalmoscopy of retina must notate:
  - 15.5.1 Vessels
  - 15.5.2 Macula
  - 15.5.3 Periphery
  - 15.5.4 Vitreous

16.0 Plan
- 16.1 Primary diagnosis must address the presenting chief complaint
- 16.2 Must address other exam findings
- 16.3 Must include treatment plan for ALL diagnoses, even if it is a "monitor" or "follow-up"
- 16.4 Clearly noted final spectacle Rx given (unless medically unable or inadvisable)

17.0 Patient Aftercare
- 17.1 Counseling and/or coordination of care with other providers or agencies is provided, consistent with the nature of the problem(s) and the needs of enrollee and/or family.
- 17.2 Summary of Care
- 17.3 Copy of exam findings readily available to patient following exam
- 17.4 Summary dictation should be sent to the referring doctor and the patient PCP at the completion of the exam to ensure patient continuity of care
- 17.5 (*COMPREHENSIVE EXAM ONL*Y) Copy of Rx must be given to enrollee at check-out (even if no change) unless medically unadvisable or unable pending a follow up
  - 17.5.1 e.g., upcoming surgical consult or follow up scheduled to fine-tune final prescription.
  - 17.5.2 Prescription cannot be withheld due to pending payment or copayment.

C. <u>Specialty Consult Examination – E&M Coding* 99202 – 99205, 99211 – 99215</u>

**Note: E&M codes allow a physician to bill for face-to-face time with patient (enrollee)/family, rather than specific exam components. Although unusual in most eye clinic settings, the following criteria must be satisfied & clearly documented to bill for physician time, rather than exam components. E&M coding may be considered eligible for post service review status on a case-by-case basis, as denoted in Table 2 below. The information below preceding Table 2 provides description of required elements as outlined in Table 2.*

1.0 Medical decision making refers to the complexity of establishing a diagnosis; determining the level of decision making consists of 3 components[3]:
- 1.1 The number of diagnosis and management options
- 1.2 Amount and/or complexity of data to be reviewed
- 1.3 Risks of significant complications, morbidity, and/or mortality

[3]AMA 2021 CPT®

2.0 Patient (Enrollee) Aftercare as defined/outlined in B 17.0

3.0 'Time Spent' refers to direct face to face time (staff/testing time do not apply) and at minimum 50% of exam time must be spent on physician-patient counseling.

3.1 Time Spent must have specified "in and out" times for calculation

3.2 Extensive counseling details may be required to be present in documentation as indicated

Table 2 (continued on page 5)

E&M Code	Patient Status	Level of Decision Making	Time Spent (Minutes)	Code Specific Required Documentation Components
99204**	New	Moderate	45-59	– History and exam elements must be documented as medically appropriate, inclusive of medical diagnosis – Extensive management options for diagnosis or treatment – Extensive counseling details – Extensive amount of data to be reviewed including: ▪ Old records, physician notes ▪ Previous or current lab results ▪ Diagnostic and imaging studies – Moderate risk of complication or morbidity or mortality of patient management ▪ Co-morbidities associated with presenting problems ▪ Risk of diagnostic procedure performed ▪ Risk associated with management options – Patient Aftercare
99205**	New	High	60-74	– History and exam elements must be documented as medically appropriate, inclusive of medical diagnosis – Extensive management options for diagnosis or treatment – Extensive counseling details – Number and complexity of problems addressed: ▪ Old records, physician notes ▪ Previous or current lab results ▪ Diagnostic and imaging studies – High risk of complication or morbidity or mortality of patient management ▪ Co-morbidities associated with presenting problems ▪ Risk of diagnostic procedure performed ▪ Risk associated with management options – Patient Aftercare

E&M Code	Patient Status	Level of Decision Making	Time Spent (Minutes)	Code Specific Required Documentation Components
99213**	Established	Low	20-29	– History and exam elements must be documented as medically appropriate, inclusive of medical diagnosis – Number and complexity of problems addressed at the encounter – Limited amount of data to be reviewed including: ▪ Diagnostic and imaging studies – Low risk of complication, morbidity or mortality of patient management ▪ Stable management of a condition ▪ Minimum risk associated with treatment options – Extensive counseling details – Patient Aftercare
99214**	Established	Moderate	30-39	– History and exam elements must be documented as medically appropriate, inclusive of medical diagnosis – Extensive management options for diagnosis or treatment – Extensive counseling details – Extensive amount of data to be reviewed including: ▪ Old records, physician notes ▪ Previous or current lab results ▪ Diagnostic and imaging studies – Moderate to high risk of complication or morbidity or mortality of patient management ▪ Co-morbidities associated with presenting problems ▪ Risk of diagnostic procedure performed ▪ Risk associated with management options – Patient Aftercare
99215*	Established	High	40-54	– History and exam elements must be documented as medically appropriate, inclusive of medical diagnosis – Extensive management options for diagnosis or treatment – Extensive counseling details – Extensive amount of data to be reviewed including: ▪ Old records, physician notes ▪ Previous or current lab results ▪ Diagnostic and imaging studies – High risk of complication or morbidity or mortality of patient management ▪ Co-morbidities associated with presenting problems ▪ Risk of diagnostic procedure performed ▪ Risk associated with management options – Patient Aftercare

**Eligible for Post Service Review*

***May be eligible for Post Service Review on a case-by-case basis*