NEW YORK STATE

MEDICAID PROGRAM

VISION CARE

PROCEDURE CODES

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GENERAL INFORMATION AND INSTRUCTIONS

1. **Fee Schedule**: The fees listed in the Vision Care Fee Schedule, available at: http://www.emedny.org/ProviderManuals/VisionCare/index.html, apply to self- employed and salaried optometrists, dispensing opticians and retail optical establishments and **are the maximum reimbursable Medicaid fees**. Ophthalmologists cannot bill using this Manual.

2. **Multiple Calls**: If an individual patient is seen on more than one occasion during a single day, the fee for each visit may be allowed.

3. **Charges for Diagnostic Procedures**: Charges for special diagnostic procedures which are not considered to be a routine part of an attending optometrist's examination or visit (e.g., gonioscopy, extended ophthalmoscopy) are reimbursable in addition to the usual optometrist's visit fee.

4. **Referral**: A referral is the transfer of the total or specific care of a patient from one practitioner to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in LEVELS of E/M SERVICE.

5. **Consultation**: Consultation is to be distinguished from referral. REFERRAL is the transfer of the patient from one practitioner to another for definitive treatment. CONSULTATION is advice and opinion from an optometry specialist called in by the attending practitioner in regard to the further management of the patient by the attending practitioner.

   Consultation fees are applicable only when examinations are provided by an optometry specialist within the scope of his specialty upon request of the attending practitioner who is treating the medical problem for which consultation is required. The attending practitioner must certify that he requested such consultation and that it was incident and necessary to his further care of the patient.

   When the consultant optometrist assumes responsibility for a portion of patient management, he will be rendering concurrent care (use appropriate level of Evaluation and Management codes). If he has had the case transferred or referred to him, he should then use the appropriate codes for services rendered (e.g., visits, procedures) on and subsequent to the date of transfer.

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6. **By Report**: A service that is rarely provided, unusual, variable, or new may require a special report in determining clinical appropriateness of the service, indicated by a "**BR**" in the Fee Schedule. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate), diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

   When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (e.g., procedure description, itemized invoices, etc.) should accompany all claims submitted.

   Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

7. **Payment in Full**: Fees paid in accordance with the allowances in the New York State Vision Care Fee Schedule shall be considered full payment for services rendered. No additional charge shall be made by a provider.

8. **Separate Procedure**: Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Separate Procedure" is applicable.

9. **Prior Approval**: Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

10. **Low Vision Services**: Low vision examination, low vision aids and fitting of low vision aids are reimbursable to self-employed optometrists specifically certified by the New York State Optometric Association to perform low vision examinations. (Code W0021 has been deleted. To report low vision examination, use codes 92002-92014.)

MMIS MODIFIERS

Under certain circumstances, the procedure code identifying a specific procedure or service must be expanded by two additional characters to further define or explain the nature of the procedure.

The circumstances under which such further description is required are detailed below along with the appropriate modifiers to be added to the basic code when the particular circumstance applies.

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-LT (Left Side): (Used to identify procedures performed on the left side of the body)
Add modifier –LT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.)

-RP (Replacement), valid for dates of service through 3/31/2009: Replacement of lost or destroyed eyeglasses may be reported by adding the modifier –RP to the eyeglass material codes and the fitting code.

-RB (Replacement), valid for dates of service on or after 4/1/2009: Replacement of lost, destroyed or broken eyeglasses may be reported by adding the modifier –RB to the eyeglass material codes and the fitting code.

-RT (Right Side): (Used to identify procedures performed on the right side of the body)
Add modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.)

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EVALUATION AND MANAGEMENT SERVICES DEFINITIONS

1. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES**: The Federal Health Care Finance Administration has mandated that all state Medicaid programs utilize the Evaluation and Management coding as published in the American Medical Association's Physicians' Current Procedural Terminology for services covered by the program.

   The E/M section is divided into broad categories such as office visits and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of optometry work varies by type of service, place of service, and the patient's status.

   The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, e.g., office consultation. Third, the content of the service is defined, e.g., comprehensive history and comprehensive examination. (See levels of E/M services following for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified.

2. **DEFINITIONS OF COMMONLY USED E/M TERMS**: Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting.

   CHIEF COMPLAINT: A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

   CONCURRENT CARE: Is the provision of similar services, e.g., visits, to the same patient by more than one practitioner on the same day. When concurrent care is provided, no special reporting is required.

   COUNSELING: Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

   - diagnostic results, impressions, and/or recommended diagnostic studies;
   - prognosis;
   - risks and benefits of management (treatment) options;
   - instructions for management (treatment) and/or follow-up;
   - importance of compliance with chosen management (treatment) options;
   - risk factor reduction; and
   - patient and family education.

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FAMILY HISTORY: A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children;
- specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
- diseases of family members which may be hereditary or place the patient at risk.

HISTORY OF PRESENT ILLNESS: A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

NATURE OF PRESENTING PROBLEM: A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal – A problem that requires the least intense level of intervention by the optometrist.
- Self-limited or Minor – A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- Low severity – A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity – A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity – A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

NEW AND ESTABLISHED PATIENT: A new patient is one who has not received any professional services from the optometrist within the past three years.

An established patient is one who has received professional services from the optometrist within the past three years and whose medical and administrative records are available to the optometrist.

In the instance where an optometrist is on call for or covering for another optometrist, the patient's encounter will be classified as it would have been by the optometrist who is not available.

PAST HISTORY: A review of the patient's past experiences with illnesses, injuries, and treatments that include significant information about:

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- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (e.g., drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status;

SOCIAL HISTORY: an age appropriate review of past and current activities that include significant information about:

- marital status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

SYSTEM REVIEW (REVIEW OF SYSTEMS): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Integumentary (skin and/or breast)
- Musculoskeletal
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems helps define the problem, clarify the differential diagnoses`, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

TIME: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions. The inclusion of time as an explicit factor beginning in 1992 is done to assist optometrist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M service codes (99202,99203,99204,99205,99212,99214,99215). Different categories of services use time differently. It is important to review the instructions for each category

Intra-service times are defined as **face-to-face time** for office visits.

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A. **Face-to-face time (e.g., office visits, office consultations)**: For coding purposes, face-to-face time for these services is defined as only that time the optometrist spends face-to-face with the patient and/or family. This includes the time in which the optometrist performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Optometrists also spend time doing work before or after face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This non face-to-face time for office services – also called pre- and post-encounter time – is not included in the time component described in the E/M codes. However, the pre- and post face-to-face work associated with an encounter was included in calculating the total work of typical services.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

3. A. **LEVELS OF E/M SERVICES**: Within each category or subcategory of E/M service, there are two to three levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services such as the determination of the need and/or location for appropriate care.

Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient. The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history; examination, medical decision making, counseling; coordination of care; nature of presenting problem, and time.

The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services.

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter. The final component, time, has already been discussed in detail.

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The actual performance of diagnostic tests/studies for which specific codes are available is **not** included in the levels of E/M services. Optometrist performance of diagnostic tests/studies for which specific codes are available should be reported separately, in addition to the appropriate E/M code.

3. B. **INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE**:

i. IDENTIFY THE CATEGORY AND SUBCATEGORY OF SERVICE: Select from the categories and subcategories of codes available for reporting E/M services.

ii. REVIEW THE REPORTING INSTRUCTIONS FOR THE SELECTED CATEGORY OR SUBCATEGORY: Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory.

iii. REVIEW THE LEVEL OF E/M SERVICE DESCRIPTIORS AND EXAMPLES IN THE SELECTED CATEGORY OR SUBCATEGORY: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time.

The first three of these components (i.e., history, examination and medical decision making) should be considered the **key** components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care (see vii.C.).

The nature of the presenting problem and time are provided in some levels to assist the optometrist in determining the appropriate level of E/M service.

iv. DETERMINE THE EXTENT OF HISTORY OBTAINED: The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused – chief complaint, brief history of present illness or problem.
- Expanded Problem Focused – chief complaint; brief history of present illness; problem pertinent system review.
- Detailed – chief complaint; extended history of present illness; problem pertinent system review extended to include review of a limited number of additional systems; pertinent past, family and/or social history directly related to the patient's problems.
- Comprehensive – chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem-oriented and does not involve a chief complaint of present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family and social history as well as a comprehensive assessment/history of pertinent risk factors.

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v. <u>DETERMINE THE EXTENT OF EXAMINATION PERFORMED</u>: The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused – a limited examination of the affected body area or organ system.
- Expanded Problem Focused – a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- Detailed – an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive – a general multi-system examination or a complete examination of a single organ system.

For the purpose of these definitions, the following body areas are recognized: head, including the face; neck; chest, including breasts and axilla; abdomen; genitalia, groin, buttocks; back and each extremity.

vi. <u>DETERMINE THE COMPLEXITY OF MEDICAL DECISION MAKING</u>: Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of optometric records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

For the purposes of these definitions, the following organ systems are recognized: eyes, ears, nose, mouth and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin, neurologic; psychiatric; hematologic/lymphatic/immunologic.

Four types of optometric decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision-making, two of the three elements in the table following must be met or exceeded:

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
minimal	minimal or none	minimal	straightforward
limited	limited	low	low complexity
multiple	moderate	moderate	moderate complexity
extensive	extensive	high	high complexity

Co-morbidities/underlying disease, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the optometric decision making.

vi. <u>SELECT THE APPROPRIATE LEVEL OF E/M SERVICES BASED ON THE FOLLOWING</u>:

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a. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (i.e., history, examination, and medical decision making), must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; and consultation.
b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (i.e., history, examination, and optometric decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient.
c. In the case where counseling and or coordination of care dominates (more than 50%) the optometrist/patient and/or family encounter (face-to-face time in the office), then time is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the optometric record.

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SERVICES SECTION

GENERAL INFORMATION AND RULES

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1. **Prior Approval**: Payment for those listed procedures in the Fee Schedule where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

2. **Complete optometric eye examination**: Codes 92002-92014 are for complete optometric eye examinations **minimally comprised** of a case history, an internal and external eye examination, objective and subjective determination of refractive state, binocular coordination testing, gross visual field testing and tonometry for recipients age 35 and over or others where indicated. Routine ophthalmoscopy and confrontational testing for visual field assessment are part of a complete optometric eye examination. The fee for the comprehensive level of complete optometric eye examination requires the use of a diagnostic pharmaceutical agent as an integral part of the service and includes reimbursement for the postcycloplegic encounter.

EVALUATION AND MANAGEMENT CODES

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

OFFICE SERVICES

The following codes are used to report evaluation and management services provided in the optometrist's office.

NEW PATIENT

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires medically appropriate history and/ or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and high level of medical decision making. When using time for code selection 40-54 minutes of total time is spent on the date of the encounter.

CONSULTATIONS (BY SPECIALISTS)

A consultation is a type of service provided by an optometrist whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another practitioner or other appropriate source.

An optometry consultant may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending practitioner and the need for consultation must be documented in the patient’s medical record. The consultant’s opinion and any services that were ordered or performed must also be documented in the patient’s medical record and communicated to the requesting practitioner.

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A “consultation” initiated by a patient and/or family is not reported using the consultation codes, but may be reported using the codes for visits, as appropriate.

Any specifically identifiable procedure (i.e., identified with a specific procedure code) performed on or subsequent to the date of the initial consultation should be reported separately.

On and subsequent to the date a consultant assumes responsibility for the management of a portion or all of the patient’s condition(s); the consultation codes should not be used.

OFFICE CONSULTATION - New or Established Patient

The following codes are used to report consultations provided in the optometrist’s office.

Follow-up visits in the consultant’s office that are initiated by the optometry consultant are reported using office visit codes for established patients (99211-99212). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending practitioner and documented in the medical record, the office consultation codes may be used again.

99241 Office or other outpatient consultation for a new or established patient, which requires these 3 key components:

- a problem focused history,
- a problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office consultation for a new or established patient, which requires these three key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are of low severity. Optometrists typically spend 30 minutes face-to-face with the patient and/or family.

99243 Office consultation for a new or established patient, which requires these three key components:

- a detailed history,
- a detailed examination, and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Optometrists typically spend 40 minutes face-to-face with the patient and/or family.

99244 Office consultation for a new or established patient, which requires these three key components:

- a comprehensive history,

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- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are moderate to high severity. Optometrists typically spend 60 minutes face-to-face with the patient and/or family.

PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN OFFICE VISIT OR OTHER OUTPATIENT SERVICE

99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

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OPHTHALMOLOGICAL DIAGNOSTIC AND TREATMENT SERVICES

REPORTING

See General Information and Rules and special ophthalmology notations listed below.

To report Evaluation and Management services, wherever performed, use descriptors from the Evaluation and Management Services (99202 et seq).

To report intermediate, comprehensive and special services, use the specific ophthalmological descriptors (92002 et seq).

DEFINITIONS:

COMPREHENSIVE OPHTHALMOLOGICAL SERVICES: A level of service in which a general evaluation of the complete visual system is made. The service includes history, general medical observation, external ocular and adnexal examination, ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated; biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and includes determination of the refractive state unless the condition of the media precludes this or it is otherwise contraindicated as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and treatment programs as indicated (e.g., the comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient)

"Initiation of diagnostic and treatment program" includes the prescription of medication, lenses and other therapy and arranging for special ophthalmological diagnostic or treatment services and consultations as may be indicated.

Prescription of lenses may be deferred to a subsequent visit, but in any circumstance is not reported separately. ("Prescription of lenses" does not include anatomical facial measurements for or writing of laboratory specifications for spectacles; for spectacle services, see 92340 et seq).

DETERMINATION OF THE REFRACTIVE STATE: Is the quantitative procedure that yields the refractive data necessary to determine the best visual acuity with lenses and to prescribe lenses. It is not a separate medical procedure, or service entity, but is an integral part of the general ophthalmological services, carried out with reference to other diagnostic procedures. The evaluation of the need for and the prescription of lenses is never based on the refractive state alone. Determination of the refractive state is not reported separately.

INTERMEDIATE OPHTHALMOLOGICAL SERVICES: A level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated: may include the use of mydriasis. Intermediate services include determination of the refractive state (unless the condition of

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the media precludes this or it is otherwise contraindicated as in presence of trauma or severe inflammation) in addition to a review of history, external examination, ophthalmoscopy, biomicroscopy and tonometry as indicated in a patient not requiring comprehensive services.

SPECIAL OPHTHALMOLOGICAL SERVICES: Services in which a special evaluation of part of the visual system is made, which goes beyond the services usually included under general ophthalmological services, or in which special treatment is given (e.g., quantitative visual field examination) should be specifically reported as special ophthalmological services. Medical diagnostic evaluation by the optometrist is an integral part of all ophthalmological services.

Technical procedures (which may or may not be performed by the optometrist personally) are often part of the service, but should not be mistaken to constitute the service itself.

Intermediate and comprehensive ophthalmological services constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, determination of refractive state, tonometry, motor evaluation, etc. is not applicable.

GENERAL OPHTHALMOLOGICAL SERVICES

The designation of new or established patient does not preclude the use of a specific level of service. For Evaluation and Management services see 99201 et seq.

NEW PATIENT

A new patient is one who has not received any professional services from the provider within the past three years.

92002 Ophthalmological services: (complete eye examination) medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient (with/without refraction)

92004 comprehensive, new patient (with/without refraction)

ESTABLISHED PATIENT

An established patient is one who has received professional services from the provider within the past three years and whose medical and administrative records are available to the provider.

92012 Ophthalmological services: (complete eye examination) medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient (with/without refraction)

92014 comprehensive, established patient (with/without refraction)

SPECIAL OPHTHALMOLOGICAL SERVICES

92020 Gonioscopy (separate procedure)

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92060 Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92065 Orthoptic and/or pleoptic training, with continuing medical direction and evaluation (LT, RT modifiers valid)
92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082 intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semi quantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083 extended examination, (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G 1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Gross visual field testing (e.g., confrontation testing) is a part of general ophthalmological services and is not reported separately.

92100 Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)
92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
92134 retina

OPHTHALMOSCOPY SERVICES

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated. It is a non-itemized service and is not reported separately.

92201 Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
92202 with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
92250 Fundus photography with interpretation and report (one or both eyes) (LT, RT modifiers valid)

OTHER SPECIALIZED SERVICES

Color vision testing with pseudoisochromatic plates is not reported separately. It is included in the appropriate general or ophthalmologic service.

92270 Electro-oculography with interpretation and report

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92273 Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld (ERG)
92274 multifocal (mfERG)

CONTACT LENS SERVICES

The prescription of contact lens includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas permeability). It is not a part of the general ophthalmological services. The fitting of contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.

Contact lenses may be supplied for the treatment of ocular pathology. A written recommendation or prescription by an ophthalmologist or optometrist is always required for contact lenses. The ophthalmologist or optometrist may also fit and dispense contact lenses.
The prescriber must maintain the following documentation in the recipient's clinical file:

- A description of the ocular pathology or medical necessity which provides justification for the recipient's need for contact lenses;
- The best corrected vision both with and without eyeglasses;
- The best corrected vision both with and without contact lenses;
- The refractive error; and
- The date of the last complete eye exam.

92310 Prescription of optical and physical characteristics of and fitting of contact lens, (includes materials) with medical supervision of adaptation (for ocular pathology); corneal lens, both eyes, except for aphakia
(Reimbursement for one eye is limited to $150.00)
(Reimbursement for both eyes requires BR)
92311 corneal lens for aphakia, one eye (LT or RT modifier valid)
92312 corneal lens for aphakia, both eyes
92313 corneoscleral lens (one or both eyes) (LT, RT modifiers valid)
92326 Replacement of contact lens (one or both eyes) (LT, RT modifiers valid)

OCULAR PROSTHETICS, ARTIFICIAL EYE SERVICES

V2623 Prosthetic eye, plastic, custom (Includes fitting and supply of ocular prosthesis and clinical supervision of adaption)
V2624 Polishing/resurfacing of ocular prosthesis
V2625 Enlargement of ocular prosthesis
V2626 Reduction of ocular prosthesis
V2627 Scleral cover shell
(When prescribed as an artificial support to a shrunken and sightless eye or as barrier in treatment of severe dry eye)
(Includes supply of shell, fitting and clinical supervision of adaption)

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SPECTACLE SERVICES (INCLUDING PROSTHESIS FOR APHAKIA)

Prescription of spectacles, when required, is an integral part of general ophthalmological services and is not reported separately. It includes specification of lens type (monofocal, bifocal, other), lens power, axis prism, absorptive factor, impact resistance and other factors.

Fitting of spectacles is a separate service reported as indicated by 92340-92371. Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography.

Supply of materials is a separate service component; it is not part of the service of fitting spectacles.

92340 Fitting of spectacles, except for aphakia; monofocal
92341 bifocal
92342 multifocal, other than bifocal
92352 Fitting of spectacle prosthesis for aphakia; monofocal
92353 multifocal
92354 Fitting of spectacle mounted low vision aid; single element system
(Includes fitting of low vision aid and visual rehabilitation),
(Reimbursable to self-employed optometrists certified to perform low vision examinations)
92355 telescopic or other compound lens system
92370 Repair and refitting spectacles; except for aphakia
92371 spectacle prosthesis for aphakia

OTHER SERVICES

76514 Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
95930 Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report
99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

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SURGERY SECTION

GENERAL INFORMATION AND RULES

1. **Follow-Up Days**: Listed dollar values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "FU DAYS" in the Fee Schedule. Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis.

2. **By Report**: When the value of a procedure is indicated as "By Report" (BR), an Operative Report must be submitted with the claim form for a payment determination to be made. The Operative Report must include the following information:
   a. Diagnosis (post-operative)
   b. Size, location and number of lesion(s) or procedure(s) where appropriate.
   c. Major surgical procedure and supplementary procedure(s)
   d. Whenever possible, list the nearest similar procedure by number according to these studies
   e. Estimated follow-up period
   f. Operative time

   Failure to submit an Operative Report when billing for a "By Report" procedure will cause your claim to be denied.

3. **Additional Services**: Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis.

4. When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

5. **Separate Procedure**: Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Separate Procedure" is applicable.

6. **Multiple Surgical Procedures**:
   a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total dollar value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified. (For reporting bilateral surgical procedures, see modifier – 50.)
   b. When an incidental procedure is performed through the same incision, the fee will be that of the major procedure only.

7. **Prior Approval**: Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

8. **MMIS Modifiers**

   -LT (Left Side): (Used to identify procedure performed on the left side of the body.) Add modifier –LT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.)

   -RT (Right Side): (Used to identify procedures performed on the right side of the body.) Add modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.)

   -50 (Bilateral Procedure): Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by the appropriate procedure code describing the first procedure. To indicate a bilateral procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum State Medical Fee Schedule amount. One claim line is to be billed. Amount billed should reflect total amount due.)

EYE AND OCULAR ADNEXA CODES

EXCISION
67820 Correction of trichiasis; epilation, by forceps only (LT, RT modifiers valid)

REPAIR
68761 Closure of the lacrimal punctum; by plug, each (LT, RT modifiers valid)

PROBING AND/OR RELATED PROCEDURES
68801 Dilation of lacrimal punctum, with or without irrigation
(For bilateral procedure, report 68801 with modifier 50)
68810 Probing of nasolacrimal duct, with or without irrigation;
(For bilateral procedure, report 68810 with modifier 50)
68840 Probing of lacrimal canaliculi, with or without irrigation (LT, RT modifiers valid)

MATERIALS SECTION

GENERAL INFORMATION AND RULES

1. **Prior Approval**: Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to

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performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

2. **By Report**: When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (e.g., procedure description, itemized invoices, etc.) should accompany all claims submitted. When billing for materials "By Report" (BR), an itemized invoice must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

3. **Lens fees**: Lens fees listed in the Fee Schedule are "per lens" for first quality plastic or glass lenses meeting F.D.A. Regulations, finished into a frame and **include** the **first three degrees of prism per lens pair**.

4. **10DS or greater lens**: A 10DS or greater lens is reimbursable at acquisition cost documented by an itemized invoice, with the full refraction indicated on it, when such cost is greater than the listed fee.

5. **Balance lens**: For code, **V2700-Balance lens**, enter 50% of the amount for the corrective lens in the amount charged field.

6. **Modifier -RP (Replacement),** valid for dates of service through 3/31/2009: Replacement of lost or destroyed eyeglasses may be reported by adding the modifier –RP to the eyeglass material codes and the fitting code.
   Modifier -RB (Replacement), valid for dates of service on or after 4/1/2009: Replacement of lost, destroyed or broken eyeglasses may be reported by adding the modifier –RB to the eyeglass material codes and the fitting code.

CODES

V2020 Frames, purchases

Sphere, single vision, per lens;

V2100 plano to plus or minus 4.00
V2101 plus or minus 4.12 to plus or minus 7.00D
V2102 plus or minus 7.12 to plus or minus 20.00D

Spherocylinder, single vision, per lens;

V2103 plano to plus or minus 4.00D sphere, 0.12 to 2.00D cylinder
V2104 plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder
V2105 plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder
V2106 plano to plus or minus 4.00D sphere, over 6.00D cylinder

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V2107 plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00D cylinder

V2108 plus or minus 4.25 to plus or minus 7.00 sphere, 2.12 to 4.00D cylinder

V2109 plus or minus 4.25 to plus or minus 7.00 sphere, 4.25 to 6.00D cylinder

V2110 plus or minus 4.25 to plus or minus 7.00 sphere, over 6.00D cylinder

V2111 plus or minus 7.25 to plus or minus 12.00D sphere, 0.25 to 2.25D cylinder

V2112 plus or minus 7.25 to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder

V2113 plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder

V2114 sphere over plus or minus 12.00D

V2115 Lenticular (myodisc), per lens single vision

V2118 Aniseikonic lens, single vision

V2121 Lenticular lens, per lens, single vision

V2199 Not otherwise classified, single vision lens

Sphere bifocal, per lens;

V2200 plano to plus or minus 4.OODS

V2201 plus or minus 4.12 to plus or minus 7.00D

V2202 plus or minus 7.12 to plus or minus 20.00D

Spherocylinder, bifocal, per lens;

V2203 plano to plus or minus 4.00D sphere, 0.12 to 2.00D cylinder

V2204 plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder

V2205 plano to plus or minus 4.00D sphere, 4.25 TO 6.00D cylinder

V2206 plano to plus or minus 4.00D sphere, over 6.00D cylinder

V2207 plus or minus 4.25 to plus or minus 7.00D sphere, 0.12 to 2.00D cylinder

V2208 plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder

V2209 plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder

V2210 plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder

V2211 plus or minus 7.25 to plus or minus 12.00D sphere, 0.25 to 2.25D cylinder

V2212 plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder

V2213 plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder

V2214 sphere over plus or minus 12.00D

V2215 Lenticular (myodisc), per lens, bifocal

V2218 Aniseikonic, per lens, bifocal

V2219 Bifocal seg width over 28 mm

V2220 Bifocal add over 3.25D

V2221 Lenticular lens, per lens, bifocal

V2321 Lenticular lens, per lens, trifocal

S0580 Polycarbonate lens
(List in addition to basic code for lens)
(Ages 21 and over require medical documentation)
(The beneficiary must be essentially monocular with functional vision in only one eye or have a history of auto aggressive behavior with a history of breaking glasses. **This documentation must be submitted with claims for beneficiaries 21 and over.** The

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statement qualifying the beneficiary's vision should be from an ophthalmologist or optometrist.)

MISCELLANEOUS

T1013 Sign language or oral interpretive services, per 15 minutes
V2410 Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430 bifocal, full field glass or plastic, per lens
V2499 Variable sphericity lens, other type
V2700 Balance lens, per lens
(**See Rule 5**, Reimbursement is limited to 50% of the corrective lens)
V2710 Slab off prism, glass or plastic, per lens
V2715 Prism, per lens **(See Rule 3)**
V2718 Press-on lens, Fresnel prism
V2745 Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens (applicable with a diagnosis code of visual sensitivity due to photophobia on the order)
V2770 Occluder lens, per lens (or plastic occluder)
V2799 Vision item or service, miscellaneous (Unlisted ophthalmic service or material)

LOW VISION AIDS

Reimbursable to self-employed optometrists certified to perform low vision examinations.

For each low vision aid, bill using the appropriate code and indicate the specific description with the corresponding maximum fee as listed in the Fee Schedule.

V2600 Hand held low vision aids and other non-spectacle mounted aids
Hand held telescope
Aloe-type clip on near telescope, 3.5X
Telesight +3.00 to +8.00
Microscopic Plastic Prism Spectacles
Aspheric Microscope (Plastic)
Cataract Aspheric Hand Magnifier

V2610 Single lens spectacle mounted low vision aids
Clear Image: One telescope including balance lens, correction lens and one or more reading caps
Bioptic: One telescope including balance lens, correction lens and one reading cap
Trioptic: One lens, telescope plus microscope and balance lens
Kollmorgan: One telescope including reading cap plus balance lens
Clear image: Microscope 3X to 20X, plus balance lens

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Bifocal Microscope: One Microscope lens 2X to 20X including dummy lens and 2 carrier lenses plus frame and case

V2615 Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system

Clear Image: Telescopes 2.2X, two lenses plus correction lenses and one or more reading caps

Bioptic: Telescopes 2.2X or 3X, two lenses including correction lenses and one or more reading caps

Trioptic: Telescopes plus microscopes, two lenses including correction lens

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