

TO: Optometrists

SUBJECT: Additional Evaluation and Management Codes and New HCPCS Procedure Codes

EFFECTIVE: Immediately and Retroactive to January 1, 1995

BACKGROUND: The Evaluation and Management (E/M) codes published in the 1995 Physicians' Current Procedural Terminology (1995 CPT) include certain codes that optometrists should utilize when submitting claims to the New Jersey Medicaid program. The intent of this Newsletter is to inform providers which E/M codes have been activated for billing by an optometrist and the corresponding levels of reimbursement.

ACTION: For services on and after January 1, 1995, providers may use the additional HCPCS procedure codes specified in the attachment when submitting the 1500 N.J. claim form. Because copyright restrictions do not permit the printing of excerpts from the CPT-4, the provider should refer to the publication for the complete description of the codes in a narrative form.

If an optometry provider rendered a service on or after January 1, 1995, that meets the definition of the HCPCS codes in this attachment and was already billed utilizing another code, the provider may submit a claim adjustment in order to receive any additional reimbursement that may be due to the provider.

In this case, the provider should submit an Adjustment Request Form (FD-999) indicating Claim Correction in block 4. A copy of a revised Claim Form indicating the applicable HCPCS Code must be attached to the Adjustment Request Form. If a claim for services provided on or after January 1, 1995, was denied for error code "237 - Procedure/provider specialty restriction," a provider can resubmit at this time.

Medicaid policy regarding the use of these additional HCPCS codes is contained in the "Qualifier" section also attached to this Newsletter.

NOTE: An optometrist will not be reimbursed for any HCPCS procedure codes not listed in this Newsletter or previously listed in subchapter 3. HCPCS (Rev. 1/94) of the Vision Care Services manual.

If you have any questions regarding this Newsletter, please contact the Vision Care Consultant, Office of Health Service Administration, Division of Medical Assistance and Health Services, at (609) 588-2721.

RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")

ATTACHMENT

Additional CPT-4 Evaluation and Management Codes and
New HCPCS Procedure Codes

HCPCS CODES MAXIMUM FEE ALLOWANCE

SPECIAL SERVICES AND REPORTS

| | |
|-------|---------|
| 99025 | \$22.00 |
| 99052 | 5.00 |
| 99082 | 4.00 |
| 99199 | BR |

OFFICE OR OTHER OUTPATIENT SERVICES

NEW PATIENT

| | |
|-------|-------|
| 99203 | 22.00 |
| 99204 | 22.00 |
| 99205 | 22.00 |

CONSULTATIONS

OFFICE OR OTHER OUTPATIENT CONSULTATIONS (NEW OR ESTABLISHED PATIENT)

| | |
|-------|-------|
| 99241 | 44.00 |
| 99242 | 44.00 |
| 99243 | 44.00 |
| 99244 | 62.00 |
| 99245 | 62.00 |

INITIAL INPATIENT CONSULTATIONS (NEW OR ESTABLISHED PATIENT)

| | |
|-------|-------|
| 99251 | 44.00 |
| 99252 | 44.00 |
| 99253 | 44.00 |

CONFIRMATORY CONSULTATIONS (NEW OR ESTABLISHED PATIENT)

| | |
|-------|-------|
| 99271 | 44.00 |
| 99272 | 44.00 |
| 99273 | 44.00 |
| 99274 | 62.00 |
| 99275 | 62.00 |

HCPCS CODES MAXIMUM FEE ALLOWANCE

EMERGENCY DEPARTMENT SERVICES (NEW OR ESTABLISHED PATIENT)

| | |
|-------|--------|
| 99281 | \$9.00 |
| 99282 | 9.00 |
| 99283 | 9.00 |
| 99284 | 9.00 |
| 99285 | 9.00 |

COMPREHENSIVE NURSING FACILITY ASSESSMENTS (NEW OR ESTABLISHED PATIENT)

| | |
|-------|-------|
| 99301 | 22.00 |
| 99302 | 22.00 |
| 99303 | 22.00 |

SUBSEQUENT NURSING FACILITY CARE (NEW OR ESTABLISHED PATIENT)

| | |
|-------|-------|
| 99311 | 16.00 |
| 99312 | 16.00 |
| 99313 | 16.00 |

DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

| | |
|-------|-------|
| 99321 | 22.00 |
| 99322 | 22.00 |
| 99323 | 22.00 |

HOME SERVICES

NEW PATIENT

| | |
|-------|-------|
| 99341 | 16.00 |
| 99342 | 16.00 |

ESTABLISHED PATIENT

| | |
|-------|-------|
| 99351 | 16.00 |
| 99352 | 16.00 |

HOUSE CALL

NEW PATIENT

| | |
|-------|-------|
| 99343 | 35.00 |
|-------|-------|

ESTABLISHED PATIENT

| | |
|-------|-------|
| 99353 | 35.00 |
|-------|-------|

HCPCS CODES

MAXIMUM FEE ALLOWANCE

OTHER EVALUATION AND MANAGEMENT SERVICES

| | |
|-------|----|
| 99499 | BR |
|-------|----|

OTHER PROCEDURES (ANTERIOR SEGMENT OF EYE)

| | |
|-------|----|
| 66999 | BR |
|-------|----|

RECONSTRUCTION

67938 \$30.00

OTHER PROCEDURES (EYELIDS)

67999 BR

INCISION AND DRAINAGE

68040 16.00

OTHER PROCEDURES (CONJUNCTIVA)

68399 BR

LACRIMAL SYSTEM

REPAIR

68761 30.00

PROBING AND/OR RELATED PROCEDURES

68800 8.00

68840 8.00

OTHER PROCEDURES

68899 BR

DIAGNOSTIC ULTRASOUND

HEAD AND NECK

76511 40.00

76511 26 18.00

76511 TC 22.00

76512 60.00

76512 26 34.20

76512 TC 25.80

76513 60.00

76513 26 24.00

HCPCS CODES MAXIMUM FEE ALLOWANCE

76513 TC \$36.00

76516 40.00

76516 26 18.00

76516 TC 22.00

76519 44.00

76519 26 20.00

76519 TC 24.00

76529 47.00

76529 26 22.00

76529 TC 25.00

OTHER PROCEDURES

76999

BR

QUALIFIER SECTION

Additional Evaluation and Management Codes and New HCPCS Procedure Codes

UNUSUAL TRAVEL (E.G., TRANSPORTATION AND ESCORT OF PATIENT)

Code 99082 may be used for travel costs only associated and billed with HOUSE CALL OR HOME VISIT. (See codes 99341, 99342, 99343, 99351, 99352 and 99353.)

OFFICE SERVICES (NEW PATIENT)

Codes 99201, 99202, 99203, 99204, 99205, 99301, 99302, 99303, 99321, 99322 and 99323 are not reimbursable with 92002, 92004, 92012 or 92014 on the same day.

When the setting for this Initial Visit is an office or residential health care facility, for reimbursement purposes it is limited to a single visit. Future use of this category of codes will be denied when the recipient is seen by the same physician, group of physicians, or shared health care facility which is a group of physicians sharing a common record. Reimbursement for an initial office visit also precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

Initial Hospital Visit during a single admission will be disallowed to the same physician, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

OFFICE SERVICES (ESTABLISHED PATIENT)

Codes 99211, 99212, 99213, 99214, 99215, 99311, 99312 and 99313 are not reimbursable with 92002, 92004, 92012 or 92014 on the same day.

HOME SERVICES AND HOUSE CALLS

House Call - 99343 and 99353

The House Call code does not distinguish between specialist and non-specialist. These codes do not apply to residential health care facility or nursing facility settings. These codes refer to a physician visit limited to the provision of medical care to an individual who would be too ill to go to a physician's office and/or is "home bound" due to his/her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a home visit.

Home Visit - 99341, 99342, 99351 and 99352

For purposes of Medicaid reimbursement, these codes apply when the provider visits Medicaid recipients in the home setting and the visit does not meet the criteria specified under House Call listed above.

The record and documentation of a Home Visit or House Call shall become part of the office progress notes and shall include, as appropriate, the following information:

1. Purpose of visit;
2. Pertinent history obtained;
3. Pertinent physical findings, including pertinent negative physical findings based on 1. and 2.;
4. Procedures, if any performed, with results;
5. Lab, X-ray, ECG, etc., ordered with results; and
6. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

CONSULTATIONS

A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice. Two types of consultation are recognized for reimbursement - comprehensive consultation and limited consultation.

COMPREHENSIVE CONSULTATION

In order to receive reimbursement for HCPCS codes 99244, 99245, 99274 and 99275, the performance of a total systems evaluation by history and physical examination, including a total systems review and total systems physical examination, are required. An alternative to that would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

Reimbursement for HCPCS codes 99244, 99245, 99274 and 99275 (Comprehensive Consultation) requires the following applicable statements, or language essentially similar to those statements, to be inserted in the "remarks" section of the claim form. The form is to be signed by the provider who performed the consultation.

Examples:

1. I personally performed a total (all) systems evaluation by history and physical examination, or
2. This consultation utilized 60 or more minutes of my personal time.

The following rules regarding consultations should also be recognized:

1. If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness, then the provider may not bill for an Initial Visit if he/she bills for the consultation.
2. If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.
3. If the patient is seen for the same illness on repeated visits by the same consultant, these visits are considered

routine visits or follow-up care visits and not consultations.

4. Consultation codes will be declined in an office or residential health care facility setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A Routine Visit code is applicable under these circumstances.
5. If a prior claim for Comprehensive Consultation visit has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the same physician, physician group, shared health care facility or physicians using a common record except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be Limited Consultation codes if their criteria are met.

LIMITED CONSULTATION

HCPCS codes 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272 and 99273, the area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as "comprehensive" as noted above (Comprehensive Consultation).

EMERGENCY DEPARTMENT SERVICES

A. Physician's Use of Emergency Room Instead of Office:

99211 When a physician sees his/her patient in the emergency room
99212 instead of his/her office, the physician must use the
same 99213 codes for the visit that would have been
used if seen in the 99214 physician's office (99211,
99212, 99213, 99214 or 99215 only). 99215 Records of that
visit should become part of the notes in the office chart.

B. Hospital-Based Emergency Room Physicians:

99281 When patients are seen by hospital-based emergency room
99282 physicians who are eligible to bill the Medicaid program,
99283 then the appropriate HCPCS code is used. The "Visit" codes
99284 are limited to 99281, 99282, 99283, 99284 and 99285.
99285