# 2024 UPDATE - MEDICAL CODING IN NEURO-OPHTHALMOLOGY

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Disclaimer: This document is not meant to be used as an official or legal coding guideline. This is an educational tool, and has not been created by a professional coder. Coding guidelines change constantly. Discuss your coding and billing practices with your facility's specialist.

Medical documentation and subsequent claim submission determine the reimbursement value of medical services. Knowledge of how to properly document and code is required for each patient encounter or service to be compensated by Medicare, Medicaid, and/or commercial payers.

Here we will attempt to outline some basic concepts related to coding with the neuro-ophthalmologist in mind. **The descriptions provided focus on the coding and documentation requirements for clinical evaluations (in-person and telemedicine).** Coding requirements for diagnostic testing and procedures are not described in this document.

## General Principles Of Billing Codes

### *Every Healthcare Professional Uses The Same Billing Codes*

There is no particular element of a neuro-ophthalmology evaluation that changes coding guidelines compared to any other type of patient. **The same rules apply to a neuro-ophthalmology patient as a general neurology patient or a general ophthalmology patient regarding criteria that must be satisfied to determine a code.** That being said, the complexity of many neuro-ophthalmology patients reaches a greater level, which may lead to a higher code, although the coding criteria must still be correctly documented. Furthermore, Eye Visit codes (920XX) can be used instead of Evaluation and Management (992XX) codes.

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This document summarizes and contextualizes information from the American Medical Association's Guidelines on Evaluation and Management codes, found at: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management and https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Additional information about Medicare implementation can be found on the CMS website: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

# Evaluation And Management Office and Consultation Codes

Effective January 1, 2021, the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) implemented major revisions related to office and outpatient E/M codes 99201–99215. One goal of these changes was to streamline the coding and documentation requirements for these commonly reported codes.

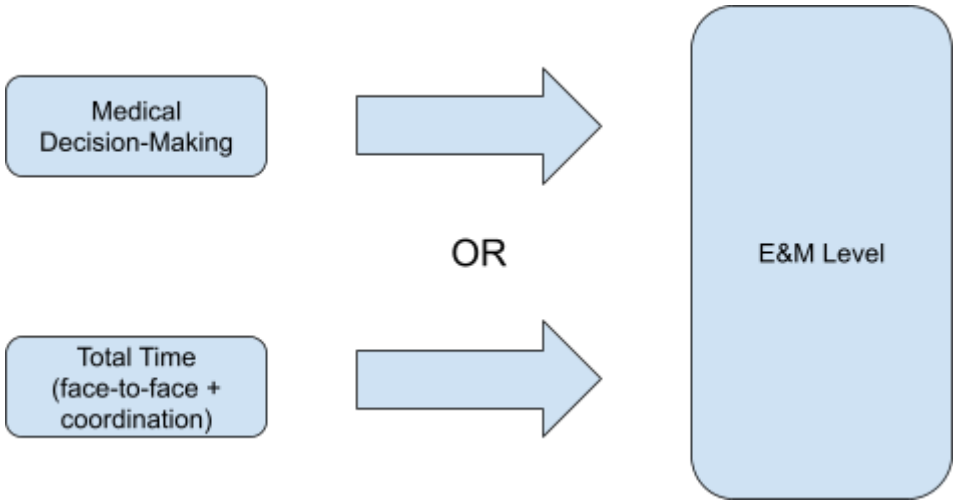
## *Background And Updates*

### Office/Outpatient E/M Coding After January 1, 2021

The AMA released new guidelines in 2021, comprehensively reforming the criteria used for selecting Office and Outpatient E/M level by **eliminating the numerical requirements for documenting clinical history and exam elements** and **shifting the decision of level to MDM-alone or time-alone** (and redefining time to **total time in the patient's care during the calendar day**). Additionally, the AMA revised the requirements used for determining the level of medical decision-making. Other changes included:

- "No more bean counting" for Outpatient Visits 99202–99215 (New and Established patients)
- Deleted 99201
- Redefined 99211 as clinical staff visit only

**Figure 1. Contributing elements to determining E&M level (2021 CPT® code set)**




### Office/Outpatient E/M Coding After January 1, 2023

The AMA revised the criteria for all other E/M codes to follow the New and Established guidelines for office/outpatient exams. This includes the documentation criteria for:

- Inpatients and outpatient consults (i.e., outpatient consults follow the same documentation criteria as outpatient office visits)
- Admissions, subsequent evaluations ("rounding"), and discharge

## Outpatient Consultation Coding After January 1, 2023

**Medicare and Medicaid no longer allow for the use of consult codes.** Some private insurance providers may also not accept consult codes, however, some still do. Discussion with your institution's billing department may be useful in determining the appropriate utilization of these codes.

### Documentation Requirements For A Consult

A consult must satisfy several elements:

1. A referring physician must have documented that they are consulting the physician regarding a specific problem. For example, a family doctor referring a patient to an ophthalmologist because the patient is due for an eye exam is not a consult.
2. The physician must document who the consulting physician is and provide an answer for the consult, as well as send documentation of this back to the consulting physician ("closing the loop").

### Outpatient Consult Codes And Billing Requirements

The outpatient consult codes (99242–99245) follow the same criteria as office E/M codes for level of service (MDM or time-alone). These requirements (including time-based requirements) are detailed below.

## *Instructions for Selecting a Level of Office or Other Outpatient E/M Services*

We will next describe the specific guidelines to create a level of service code.

## General Principles For Selecting the Appropriate Level of E/M Service

As of January 1, 2021, the appropriate level of E/M services is selected based on the following:

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

Although **documentation of the history and physical exam are still required**, there is no specific amount of detail that is required for each level of service, but rather a more general, "medically appropriate" documentation is required.

## Elements Of Medical Decision Making (MDM)

See also this table from the American Medical Association:
https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

MDM has always consisted of three elements: establishing diagnoses, assessing the status of a condition, and/or selecting a management option. The general principles for these elements can be summarized as:

1. **Diagnosis (Problem):** How complex is the problem (or problems) being managed during the visit?
2. **Data:** How much data was reviewed and analyzed for the visit?
3. **Risk:** What is the morbidity/risk to the patient for diagnostic evaluation or treatment?

Each of these elements are then classified into low, moderate, and high tiers, and the highest two of the three elements are then used to determine the appropriate E&M level.

The methodology for quantifying and then stratifying these elements changed significantly beginning in 2021. While the “highest complexity two of three” rule still applies, the new guidelines simplified the process.

**Diagnosis (Problem)**

The diagnosis (or problem) component of MDM is defined as the number and complexity of problem(s) addressed during the encounter.

Problems that the patient may have but were not specifically addressed during the visit would not count.

**Example**

Asymptomatic and untreated blepharitis in a patient with a pituitary adenoma would **NOT** count towards the complexity of the diagnosis.

However, problems that the patient has that may contribute to the patient's morbidity may be important to include in the diagnosis list.

> **Example**
>
> Diabetes and hypertension in a patient being seen for anterior ischemic optic neuropathy **WOULD** contribute to the complexity of the diagnosis and should be considered for inclusion in the problem list. Other comorbid diagnoses could also include sudden vision loss and visual field defect.

Previously, the complexity of a patient's problem was determined by a combination of the number of diagnoses, how many new vs. established conditions were being addressed, if established conditions were worsening or improving, and tabulating these elements using a point-based matrix to report the complexity.

Since 2021, the guidance on determining complexity has been simplified, and the verbiage acknowledges that while the final diagnosis may not be complex on its face (i.e., dry eye syndrome), the symptoms and process that led to determining the diagnosis may have been complex and should be considered when selecting the complexity level. Factors like patient's age, chief complaint or patient comorbidities also contribute to the acuity of the problem.

> *The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore,* ***presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid.*** *The evaluation and/or treatment should be consistent with the likely nature of the condition.* **(emphasis added)**

**Data**

Data is defined as the amount and/or complexity of data to be reviewed **and** analyzed. These data include medical records, tests, and/or information that must be obtained, ordered, reviewed, and analyzed for the encounter.

Data are divided into three categories:

- **Tests, documents, orders, or independent historian(s).** Each unique test, order, or document is counted to meet a threshold number.

  *Example:* A neuro-ophthalmologist reviews 1 clinic note and labs including ESR, CRP, and CBC. A total of 4 items contribute to the threshold number (note that the different elements of the CBC, while reviewed individually, are part of a single unique test, whereas ESR and CRP are each considered unique tests). Recording someone else's interpretation of a diagnostic test result is also included in this category.

- **Independent interpretation of tests.**

  *Example:* A neuro-ophthalmologist, as part of their review, documents a personal interpretation of a provided visual field, OCT optic nerve, and MRI.

- **Discussion of management or test interpretation.**

  *Example:* A neuro-ophthalmologist independently reviews an outside MRI and then discusses the MRI interpretation with a neuroradiologist.

**Risk**

Risk is defined as "the risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).

This includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family.

*Example:* A patient is diagnosed with papilledema by the neuro-ophthalmologist. As part of the counseling, the neuro-ophthalmologist recommends that the patient undergo additional testing, including an MRI with contrast, MRV without contrast, and lumbar puncture with opening pressure and CSF studies. The risks and potential complications of each diagnostic test, especially with lumbar puncture (which can include CSF leak, infection, paralysis, and death), are reviewed with the patient.

*Example:* A patient is diagnosed with a partial third nerve palsy by the neuro-ophthalmologist. As part of the counseling, the neuro-ophthalmologist recommends that the patient undergo emergent vascular neuroimaging such as a CTA or MRA to evaluate for a cerebral aneurysm, which can be life-threatening or result in permanent neurological deficits.

**Table 1: American Medical Association 2021 Guidelines On Management Risk**

| Code | Risk of Complications and/or Morbidity or Mortality of Patient Management |
|---|---|
| 99211 | NA |
| 99202/99212 | Minimal risk of morbidity from additional diagnostic testing or treatment |
| 99203/99213 | Low risk of morbidity from additional diagnostic testing or treatment |
| 99204/99214 | Moderate risk of morbidity from additional testing or treatment<br>Examples only:<br>• Prescription Drug Management<br>• Decision regarding minor surgery with identified patient or procedure risk factor<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| 99205/99215 | High risk of morbidity from additional diagnostic testing or treatment<br>Examples only:<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision for minor surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

*Source: American Medical Association*

Here are three examples of factors affecting the risk to the patient:

- **Low morbidity, minimal risk:** Straightforward
- **Social determinant of health considerations:** Moderate risk
- **Drug therapy requiring intensive monitoring:** High risk

## Social Determinants of Health

Social determinants of health are recognized as contributing factors to the complexity of medical decision making. These factors are categorized as Z-codes within the ICD-10 coding set. Individual factors within each category are defined by institution. The AMA suggests including these codes to provide additional data for complexity.

CMS has released an infographic regarding the use of Z-codes for social determinants of health: https://www.cms.gov/files/document/zcodes-infographic.pdf

## Calculating the Medical Decision Making Complexity

Four types of MDM are recognized: straightforward, low, moderate, and high. To qualify for a particular level of MDM, **two** of the three elements for that level of MDM must be met or exceeded. Here are some general case scenarios for the types of problems commonly seen by neuro-ophthalmologists and their suggested level of complexity.

**Straightforward Complexity *(1 self-limited or minor problem)***

*Examples:*

- Patient seen for IOP check by technician
- Patient presents with subconjunctival hemorrhage

**Low Complexity *(2 or more self-limited or minor problems or 1 stable chronic illness or 1 acute/uncomplicated illness or injury)***

*Examples:*

- Follow-up visit to re-assess treated mild IIH and papilledema without visual field defects or any visual symptoms with plan to continue acetazolamide, OCT ordered and reviewed
- Follow-up visit of a patient with basic esotropia and diplopia without neurological disease

**Moderate Complexity (1 or more chronic illness with exacerbation/progression or side effects of treatment *or 2 or more stable chronic illnesses or 1 undiagnosed new problem with uncertain prognosis or 1 acute illness with systemic symptoms or 1 acute complicated injury)***

*Examples:*

- Patient with moderate IIH, papilledema, and visual field defects that is responding to treatment
- Established patient with previous NAION presenting with new vision loss; ordered 2 labs and imaging
- New referral for intermittent vision loss and headache, previous MRI and labs reviewed, previous visual fields interpreted, previous clinic records reviewed, diagnosed with dry eyes and migraine

**High Complexity (1 or more chronic illness with severe exacerbation/progression or side effects of treatment *or 1 acute or chronic illness or injury that poses a threat to life or bodily function)***

*Examples:*

- Patient with new onset of vision loss and temporal headaches, GCA suspected
- Patient referred for unexplained vision loss and concerns of life-threatening or sight-threatening disease; independent review of imaging; ordering 2 labs and 1 imaging, review of previous clinic records and hospital records, placed on high-dose steroids

## Table 2: American Medical Association Guidelines For Determining Level of E/M Service

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| | | **Number and Complexity of Problems Addressed** | **Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*** | **Risk of Complications and/or Morbidity or Mortality of Patient Management** |
| **99211** | **N/A** | N/A | N/A | N/A |
| **99202**<br>**99212** | **Straightforward** | **Minimal**<br>• **1** self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| **99203**<br>**99213** | **Low** | **Low**<br>• **2** or more self-limited or minor problems;<br>**or**<br>• **1** stable chronic illness;<br>**or**<br>• **1** acute, uncomplicated illness or injury | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories*)<br><br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • review of the result(s) of each unique test*;<br>  • ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)** | **Low risk of morbidity from additional diagnostic testing or treatment** |
| **99204**<br>**99214** | **Moderate** | **Moderate**<br>• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>**or**<br>• **2** or more stable chronic illnesses;<br>**or**<br>• **1** undiagnosed new problem with uncertain prognosis;<br>**or**<br>• **1** acute illness with systemic symptoms;<br>**or**<br>• **1** acute complicated injury | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |

| | | | | |
|---|---|---|---|---|
| **99205**<br>**99215** | **High** | **High**<br>• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function | **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | **High risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

*Source: American Medical Association*

## Additional Case Examples:

**"Level 4, not Level 3": Dx Treated + Data Reviewed and Analyzed + Risk / Patient Management**

*Common Scenarios*

1. Two stable chronic illnesses **AND** Rx Management/Social Determinants of Health (e.g. DM/HTN on Lipitor or IIH/Migraines on acetazolamide or MG/Diabetes on steroid sparing agent)
2. One Chronic Illness with Exacerbation/Progression **AND** Rx Management/Social Determinants of Health (e.g. GCA worsening with access to Rx issues or IIH worsening that needs higher dose of acetazolamide)
    - Substitute "3 tests ordered" for
        - Three unique lab tests (a panel = 1 lab)
        - Combination of 3 total lab(s), imaging(s) or test(s) in the Medicine section

**"What is a Level 3?": Dx Treated + Data Reviewed and Analyzed + Risk / Patient Management**

*Common Scenarios*

1. Acute uncomplicated illness **AND** OTC medication (e.g. dry eyes, take artificial tears or allergic conjunctivitis, take ketotifen or mild tension headache, take ibuprofen)
2. One stable or improving chronic illness **AND** <3 tests **AND** NO Rx (e.g. cancer survivorship w/ NO other chronic condition, no Rx or IIH in remission w/ no other chronic condition and no Rx)

**With the new guidelines, many cases that were previously considered a level 3 exam under the previous guidelines may actually satisfy requirements for a level 4 exam.**

## Coding Based on Time

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services.

### 2021 Change to Time Calculations

A key shift for the office and other outpatient E/M codes is that the time referenced in the 2021 code descriptors is **total time**. The 2020 descriptors for these codes used intraservice time.

*Example:* A neuro-ophthalmologist, on the date of service, spends 10 minutes reviewing previous records and interpreting previous diagnostic tests, spends 20 minutes face-to-face with the patient, and spends 15 minutes coordinating care, completing charting requirements, and discussing the case with the patient's referring physician. The time used for level of service determination would be 45 minutes (10+20+15).

### Time-Based Codes Require A Face-To-Face Encounter

The E/M services for which these guidelines apply **require a face-to-face encounter with the physician or other qualified healthcare professional**.

For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

Use CPT code 99211 for office or outpatient services that do not require face-to-face time with the physician (e.g., technician-only IOP check).

### Qualifying Activities That Can Be Counted Within Time-Based Determination

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures

- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)
- **NOTE: UNSUPERVISED RESIDENT TIME DOES NOT COUNT (however, supervised resident time, including teaching discussions SPECIFIC to the patient, DO count)**

## 2021 Time Requirements for E/M Codes (based on TOTAL time)

**Table 3: Time Requirements For E/M Office/Outpatient Codes**

| CPT® | New 99202 | Established 99212 | New 99203 | Established 99213 | New 99204 | Established 99214 | New 99205 | Established 99215 |
|---|---|---|---|---|---|---|---|---|
| Time (min) | 15-29 | 10-19 | 30-44 | 20-29 | 45-59 | 30-39 | 60-74 | 40-54 |
| MDM | Straightforward | | Low | | Moderate | | High | |
| History | Medically appropriate | | Medically appropriate | | Medically appropriate | | Medically appropriate | |
| Exam | Medically appropriate | | Medically appropriate | | Medically appropriate | | Medically appropriate | |

*Source: American Medical Association*

## 2023 Time Requirements for E/M Consult Codes (based on TOTAL time)

**Table 4: Time Requirements for E/M OUTPATIENT CONSULT Codes**

| Code | Time Range |
|---|---|
| 99242 | 20–29 minutes |
| 99243 | 39–49 minutes |
| 99244 | 40–54 minutes |
| 99245 | 55–70 minutes |

**Table 5: Time Requirements for INPATIENT ADMISSIONS Codes**

| Code | Time Range |
|---|---|
| 99221 | 40–54 minutes |
| 99222 | 55–74 minutes |
| 99223 | 75–89 minutes |

**Table 6: Time Requirements for INPATIENT SUBSEQUENT EVALUATION Codes**

| Code | Time Range |
|---|---|
| 99231 | 25–34 minutes |
| 99232 | 35–49 minutes |
| 99233 | 50–64 minutes |

**Table 7: Time Requirements for INPATIENT CONSULT Codes**

| Code | Time Range |
|---|---|
| 99252 | 35–44 minutes |
| 99253 | 45–59 minutes |
| 99254 | 60–79 minutes |
| 99255 | 80–94 minutes |

## *When To Bill Based On MDM vs. Time?*

The information provided above provides a general framework for determining the appropriate situations to bill based on MDM vs. time. Every billable encounter should be individually considered, but similar cases will likely be billed similarly. Tables 8 and 9 suggest how to consider when to select MDM or time as the basis for E/M levels of complexity.

**Table 8: Framework for Considering New Outpatient E/M Complexity Level**

| **New Patients** | |
|---|---|
| **If time is…** | **Bill for…** |
| < 45 minutes | **MDM** |
| 45–59 minutes<br>MDM = *Not* high | **Time**<br>- 99204 |
| 45–59 minutes<br>MDM = High | **Time**<br>- 99205 |
| 60–74 minutes | **Time**<br>- 99205 |
| ⩾ 75 minutes | **Time**<br>- 99205<br>- 99417 for each additional 15 minutes |

## Table 9: Framework for Considering Established Outpatient E/M Complexity Level

| **Established Patients** | |
|---|---|
| **If time is…** | **Bill for…** |
| < 30 minutes | **MDM** |
| 30–39 minutes<br>MDM = *Not* high | **Time**<br>- 99214 |
| 30–39 minutes<br>MDM = High | **Time**<br>- 99215 |
| 40–54 minutes | **Time**<br>- 99215 |
| ⩾ 55 minutes | **Time**<br>- 99215<br>- 99417 for each additional 15 minutes |

# Prolonged Services

There are two types of prolonged service:

1. On the same date of the encounter with the patient

2. On a different date from the encounter without face-to-face contact with the patient

## *Prolonged Services On Same Date Of Encounter With The Patient: 99417 and G2212*

99417 and G2212 are similar but slightly different in time application. 99417 applies for commercial insurances, G2212 applies for Medicare. Here is a table to show the differences.

| New | | |
|---|---|---|
| **Time (minutes)** | **Medicare** | **Commercial** |
| 15-29 | 99202 | 99202 |
| 30-44 | 99203 | 99203 |
| 45-59 | 99204 | 99204 |
| 60-74 | 99205 | 99205 |
| 75-89 | 99205 | 99205 + 99417 |
| 89-104 | 99205 + G2212 | 99205 + 99417 x2 |
| 105-119 | 99205 + G2212 x 2 | 99205 + 99417 x3 |
| 120-134 | 99205 + G2212 x 3 | 99205 + 99417 x4 |

| Established | | |
|---|---|---|
| **Time (minutes)** | **Medicare** | **Commercial** |
| 10-19 | 99212 | 99212 |
| 20-29 | 99213 | 99213 |
| 30-39 | 99214 | 99214 |
| 40-54 | 99215 | 99215 |
| 55-69 | 99215 | 99215 + 99417 |
| 70-84 | 99215 + G2212 | 99215 + 99417 x 2 |
| 85-99 | 99215 + G2212 x 2 | 99215 + 99417 x 3 |
| 100-114 | 99215 + G2212 x 3 | 99215 + 99417 x 4 |
| 115-129 | 99215 + G2212 x 4 | 99215 + 99417 x 5 |

CPT code 99417 (G2212 for Medicare) is only used when the office or other outpatient service has been selected using time alone as the basis and only after the total time of the highest-level service (ie, 99205 or 99215) has been exceeded. These codes are also used for inpatient services.

- To report a unit of 99417, 15 minutes of additional time must have been attained from the minimum time value required. For example, 99205 is the appropriate code for a new office E/M visit with a total time between 60–74 minutes. 99417 should be used starting at 75 minutes (60+15 minutes).
- Do not report 99417 for any additional time increment of less than 15 minutes. For example, a new office E/M visit with a total time of 71 minutes would only be coded as 99205 without 99417.
- G2212 requires prolonged services based on 15 minutes of additional time after the maximum time value required has been satisfied. For example, if 99205 for new office E/M visits requires a total time between 60–74 minutes, G2212 cannot be used until a total of 90 minutes has been spent on the patient's care (75+15 minutes).

**Summary:** 99417 and G2212 have different time criteria, as the AMA code (99417) is based on minimum time and the Medicare code (G2212) is based on the maximum time. In other words, 99417 is satisfied if your services extend 1 minute above the previous time period, but G2212 requires that you provide extended services for the entire 15-minute period before it is satisfied.

******G2212 and G2211 should not be confused. See below for what is G2211***.

## Limits to the Use of Prolonged Service Codes

According to the AMA, **there is no limit to the number of prolonged service codes that can be used for an E/M service** (https://edhub.ama-assn.org/steps-forward/module/2813035). For example (see below for another example), an established visit that takes 120 minutes between extensive counseling and coordination of care could result in the coding of 99417 five times (or G2212 four times).

**Caveat:** Despite the guidance from the AMA, the reimbursement and approval of prolonged service codes varies by carrier, region, and institution.

## Prolonged Service Office Documentation Example:

*Office visit for an adult diabetic established patient with a history of recurrent sinusitis who presents with a one-week history of double vision. The spouse states that she has some unsteady gait as a result of this. A medically appropriate exam was performed.*

***I spent 80 minutes with the patient today**. I personally reviewed the CT scan, which shows a periorbital abscess. I reviewed the lab results from her primary care visit on 9/27/20. I have*

*ordered a blood culture to check for bacteria in the sample. I explained to the patient and spouse that we will treat with a course of antibiotics.*

**Code:** 99215 x 1 and 99417 x 2.

## *Prolonged Services On A Different Date Of Encounter: 99358 and 99359*

**Caveat:** These codes are no longer recognized by CMS but may still be accepted by other insurance carriers.

This service is to be reported in relation to other physician or other qualified healthcare professional services, **performed on a different date than the primary service to which it is related**. For example, extensive record review may relate to a previous evaluation and management service performed at an earlier date. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.

Codes 99358 and 99359 are used for the total duration of prolonged services on a date other than the date of a face-to-face encounter, even if the time spent on that date is not continuous.

*Example:* A patient is seen for an office E/M visit on date XX-XX-XXXX. 2 days prior to the patient's visit, the neuro-ophthalmologist spent 15 minutes reviewing the patient's chart. Later that day, the neuro-ophthalmologist spent an additional 32 minutes "pre-charting" the patient's medications, past medical history, and summary of previous clinical records. A total of 47 minutes (15+32 minutes) would be applicable for this service.

- **99358** is used to report the **first hour of prolonged service** on a given date regardless of the place of service. It should be used only once per date. Prolonged service of **less than 30 minutes total duration on a given date is not separately reported**.
- **99359** is used to report **each additional 30 minutes beyond the first hour**. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

**Table 10: Framework For Determining Prolonged Services On Different Date Of Service**

| Total Time | Code(s) |
|---|---|
| <30 minutes | — |
| 30–74 minutes | 99358 |
| 75–104 minutes | 99358 + 99359 |

| | |
|---|---|
| 105–134 minutes | 99358 + 99359 + 99359 |

**Figure 2: Using Prolonged Service Codes On Different Date Than Encounter**


## Limits to the Use of Prolonged Service Codes

Although 99358 is only used once on any given date of service, there is no limit to the number of times 99359 can be used (30-minute increments).

## Prolonged Service On Separate Date Documentation Example

*An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. She is brought to the neuro-ophthalmology office by her daughter and has been examined by the physician. The physician indicated that past medical records would be obtained from the patient's prior physicians and that he will communicate further with the daughter upon review of the medical records.*

*The medical records were obtained 4 days after the office visit. 36 minutes were spent in review of the extensive medical records and an additional 31 minutes were spent in coordination of care, for a total of 67 minutes spent in direct patient care.*

**Code:** 99358.

# Additional Topics: Eye Codes

Eye codes are another option for coding, which have slightly different reimbursement rates and documentation requirements.

## *Intermediate Eye Exam: New (92002) and Established (92012)*

These exams are defined as the evaluation of new or existing ocular conditions, including:

1. History, chief complaint, past medical history (PMH), medications and allergies
2. General medical review of systems (ROS)
3. Examination of external eye and adnexa

## *Comprehensive Eye Exam: New (92004) and Established (92014)*

These exams are defined as the evaluation of complete visual system, including:

1. History, chief complaint, PMH, medications and allergies
2. General medical ROS
3. Gross visual fields
4. All 12 elements of the exam
5. Ophthalmoscopy (may require dilation). If you do not dilate, document the reason why; every chart audit looks for dilation when auditing a Comprehensive Eye Visit code.

# Additional Topics: Special Testing

Fundus photo, visual field, OCT interpretation, and the sensorimotor exam, are other exam elements that may allow additional coding and reimbursement. Similarly, certain criteria need to be met to code these procedures correctly.

## *Sensorimotor Exam (92060)*

This refers to a quantitative sensorimotor exam, which is separate and in addition to the basic sensorimotor exam (e.g., orthophoric in primary position) in the comprehensive eye exam. The sensorimotor exam requires recording ocular alignment measurements in more than one field of gaze (e.g., distance and near, left and right gaze). In addition, a test of sensory function must be included. This can be the Worth 4-dot test, Maddox rod testing, color vision, or stereovision testing.

The sensorimotor exam must be attached as a code to only certain diagnoses. For example, you cannot get reimbursed if you link the sensorimotor exam code to the diagnosis of 'headache.' Examples of diagnoses that typically allow this procedure code include diplopia, nystagmus, esophoria, exophoria, and hypertropia.

## *Ancillary Testing: Fundus Photos, Visual Fields, Optical Coherence Tomography (OCT)*

Fundus photos, visual fields, and OCT interpretation can all be coded. Fundus photos and OCT cannot both be billed if performed on the same date of service. Similar to the sensorimotor exam, only certain diagnoses are acceptable to reimburse for these procedures. They are too numerous to list here, but your billing specialist can provide you with a list. Macular and RNFL OCTs have separate diagnostic allowances but are typically not separately billable during the same visit (i.e., can only bill for macular OCT or RNFL OCT for the day). Similarly, fundus imaging and OCT are typically not billable together during the same visit.

To get reimbursed, a report interpretation is needed. Three categories should be included in the report:

1. Clinical findings
2. Comparative data/change in condition
3. Clinical management (what is being done regarding the patient's care in regards to this test result)

Document that you have ordered these tests and why within your note, as it helps prove medical necessity for the test if you are audited.

## Interpretation Of Ancillary Testing

There may be situations in which an in-person clinical evaluation is not required by a referring provider; rather, they may simply be requesting consultation for the performance and interpretation of an ancillary test. An example may be a neurosurgeon requesting a visual field interpretation on a patient with a known pituitary mass and an established eye doctor who does not have a visual field machine, or a neurologist requesting formal visual field testing on a patient with an occipital lobe stroke.

Although the implementation of a service of this nature is institution-dependent, the mechanics of offering this service would be similar to that of other diagnostic test referrals in neurology, such as sleep studies, video electroencephalograms, electromyography/nerve conduction studies, etc., in which the interpreting physician may not have a treating relationship with the patient but still provides a diagnostic service and interpretation.

Billing for these ancillary tests would be the same as if the patient had an office E/M visit in conjunction with the ancillary tests, with documentation of the ancillary test, indication, and interpretation as detailed above.

# Additional Topics: Telehealth Codes

Since the COVID-19 pandemic, reimbursement, guidelines, and definitions for telehealth codes have varied greatly, and are constantly evolving. Depending on institution, region, and insurance carrier, these codes are heterogeneously reimbursed/allowed. Additionally, some cases (especially asynchronous telehealth-related services) may end up being better-addressed via video telemedicine or in-person office visits. The discussion in this section refers to telehealth codes that may be of interest to the neuro-ophthalmologist.

## *Video Visits*

As of 2024, video visits are coded using the same E&M codes as face-to-face visits based on time (total time day of encounter with and without patient) or MDM.

### Prolonged Service Codes For Video Visits

99417/G2212 can be used for prolonged services on the same day as the encounter (both face-to-face and non face-to-face), and follow the same time-based criteria described above.

## *Telephone Telehealth Visits*

Telephone service codes (99441–99443) are described for evaluation/management services performed by physicians or other advanced healthcare providers over the telephone. These are time-based codes and are based on **time spent in medical discussion**. Telephone evaluations less than 5 minutes in duration are not billable.

**Table 11: Time Requirements for Telephone E/M Visits**

| CPT | Time |
|---|---|
| 99441 | 5–10 minutes |
| 99442 | 11–20 minutes |
| 99443 | 21–30 minutes |

## *Asynchronous Digital Health Visits*

Digital health visit codes (99421–99423) are described for evaluation/management services performed by physicians or other advanced healthcare providers over asynchronous digital message, such as a secure portal in an electronic health record (EHR) system. These are time-based codes and are based on the total time spent over 7 days.

**Table 12: Time Requirements for Digital Health Visits**

| CPT | Time |
|---|---|
| 99421 | 5–10 minutes |
| 99422 | 11–20 minutes |
| 99423 | 21–30 minutes |

## *Interprofessional Consultations (eConsults)*

Interprofessional consultations are described for services provided by a consulting provider to a referring provider unrelated to an in-person E/M evaluation. A common example is the so-called “curbside” consultation, in which a consulting provider is asked to review a limited amount of clinical data, often in conjunction with telephone, video, or in-person discussion with the referring provider, and provide “next step” recommendations in evaluation or management.

Patient consent for billing must be obtained (written or verbal) prior to the submission of this code.

These codes may be time-based (99446–99449) and are based on the total time for discussion and review; these codes require both a verbal and written report provided to the referring provider. 99451 is used for written-only reports (i.e., consults provided without direct discussion with the referring provider).

**Table 13: Time Requirements for Interprofessional Consultations**

| CPT | Time |
|---|---|
| 99446 | 5–10 minutes |
| 99447 | 11–20 minutes |
| 99448 | 21–30 minutes |
| 99449 | >30 minutes |
| 99451 | ≥5 minutes |

## *Virtual Check-In Visits*

A “virtual check-in” is defined as a brief communication with established patients to “decide whether an office visit or other service is needed.” These visits are initiated by the patient and are used to answer the question, “does the patient need to be seen?” The call cannot be within 7 days of the last visit. Although many of these triage-related questions may be answered with well-trained staff, there are sometimes more complex issues that require the physician to directly communicate with the patient.

### When Is A Virtual Check-In Billable?

If the answer is “no, the patient does not need to be seen,” or if the answer is “yes, the patient can be seen at the next available clinic date,” this visit may be billable (G2012).
If the answer is “yes, the patient should be seen urgently (within 24 hours),” the visit is NOT billable and would be incorporated into the E/M visit (which would likely be a higher complexity).

*Example:* A patient previously seen for papilledema calls with new-onset vision loss and headache, asking “do I need to come in?” After a brief discussion on the phone, the neuro-ophthalmologist determines that the new-onset vision loss is actually mild transient blurred vision related to a migraine and recommends follow-up as previously scheduled.

**Code:** G2012

## *Remote Evaluation of Pre-Recorded Patient Information*

The service of reviewing patient-submitted pre-recorded information (photos or videos) is also a billable service by CMS. Similar to the virtual check-in, this code is intended to “assess whether a visit is needed” and cannot be related to a previous visit within the last 7 days, and cannot lead to a visit in the following 24 hours.

*Example:* A patient being followed for myasthenia gravis sends a series of photos with mild ptosis, asking if they need to be seen. After reviewing the images, the neuro-ophthalmologist concludes that the ptosis is mild and does not require additional intervention, recommending routine follow-up.

**Code:** G2010

## *Remote Interpretation of Ancillary Diagnostic Testing*

As discussed in the Ancillary Testing section above, some patients may be referred to a neuro-ophthalmologist for the sole purpose of obtaining a diagnostic test and interpretation.

# Additional Topics: Additional Complexity To E/M Evaluation

For additional information, see the following CMS document:
https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

Beginning January 1, 2024, CMS allowed the reimbursement for code **G2211**, which represents additional complexity inherent to the long-term management of a serious or complex condition or the focal-point management of needed services. Although this code may be utilized more in primary care, high-complexity subspecialties such as neuro-ophthalmology may also utilize this code when we are the continuing focal point for all needed services, such as in idiopathic intracranial hypertension or pituitary macroadenomas. G2211 may also be utilized for ongoing care of a single serious or complex condition, which could represent the ongoing care of patients with rare diseases that have either serious visual or systemic implications, such as Leber hereditary optic neuropathy, or high complexity of care, such as thyroid eye disease.

**How is G2211 used?** HCPCS Code G2211 (https://youtu.be/0i9TsYP3NdA)

- G2211 (definition below) is an add-on code to office and other outpatient services, 99202–99215.
- CMS believes it will be used by primary care and other specialties that treat a single, serious condition or a complex condition with consistency and continuity over a long period of time. CMS is emphasizing the longitudinal relationship between the practitioner and the patient.
- CMS will not allow G2211 to be used with an E/M service if modifier 25 is used.
- With budget neutrality, there is pressure on Congress from some specialties not to allow implementation. **We'll see what Congress does in their year-end spending bills.** https://codingintel.com/hcpcs-add-on-code-for-e-m-visit-complexity/

**Caveat:** the recognition and reimbursement of this code is still highly variable across institutions, regions, and is still largely limited to Medicare or Medicaid patients. Consultation with your institution's billing department is warranted.

# Conclusion

Coding rules are highly regulated and specific, yet they contain subjective and arguable elements. The physician is expected to have a general knowledge of coding rules and understand how to code appropriately. The neuro-ophthalmologist has challenges in that patients are often more complex, but that does not necessarily guarantee a higher code. This is why understanding the coding process is the best way to ensure accurate coding and maintain security in your practice.