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HIGHMARK CODING TIPS

August 2021

Reporting Fundus Photography and (SCODI) Services

When reported on the same eye and date of service, Fundus photography is bundled into scanning computerized ophthalmic diagnosis imaging (SCODI) based on National Correct Coding Initiative (NCCI) edits. It is considered a 'yellow' code combination in which a modifier can be used to override the edit (i.e., Modifiers 59, XE, XP, XS and XU).

However, it is not expected to see frequent reporting of these services performed together. A provider would typically use one technique or the other to evaluate fundal disease. Because technology sometimes allows for simultaneous capture of these images, it is important for a provider to determine the patient's condition and which structure or image is the most clinically appropriate. The November 2014 CPT Assistant states: "It is important to note that if the only necessary service provided is generating a fundus photograph without the need to quantify the nerve fiber layer thickness and to analyze the data via a computer, then reporting code 92250 is appropriate, even if the photograph was taken with a scanning laser."

If a provider would report fundus photography and SCODI on the same patient and date of service, Highmark would expect the documentation to clearly indicate the rationale to support both services on the same eye. Of note, both 92133 and 92134 are unilateral or bilateral codes that require the use of RT and LT modifiers and 92250 is a bilateral service whereas these modifiers are not required.

For further clarification of bilateral procedures, please reference the Highmark Provider Manual.

Reporting Time Based Procedures

(supersedes December 2006 PRN article and August 2018 Highmark Coding Tip)

Highmark requires that a qualified health care professional document time in a member's record when they perform time-based services. Examples of this are some psychiatry codes, anesthesia, certain therapy modalities, critical care, second level discharge visit, and prolonged services (this is not an all-inclusive list). Basically, if the definition of a CPT code lists time, document time in the medical record. The documentation of time should be recorded with both the start/stop times and the total time treating the patient.

Calculating and reporting time-based codes

According to American Medical Association Current Procedural Terminology (AMA CPT®), beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient evaluation and management (E/M) services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service.

Per CPT time guidelines, unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary, time is the face-to-face time with the patient.

A unit of time is attained when the midpoint is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and 60 minutes). A second hour is attained when 91 minutes have elapsed. Additionally, when codes are ranked in sequential typical times, and the actual time is between two typical times, use the code with the typical time closest to the actual time (e.g., psychotherapy codes).

Multiple units can be reported per date of service for one or more procedures based on the aggregate amount of time spent by a qualified health care professional in direct contact with the patient (e.g., Physical Therapy codes). However, the number of units billed cannot exceed the overall time spent treating the patient.

Calculating and reporting Anesthesia time

Anesthesia time begins when the anesthesia provider is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the provider is no longer in personal attendance: that is, when the patient may be safely placed under customary postoperative supervision. However, when epidural anesthesia care is provided either 1) during labor only, or 2) during labor and vaginal delivery, code 01967 should be reported. The total time reported should reflect actual time in personal attendance (i.e., “face time”) with the patient.
Note: different categories of services may have different documentation rules, therefore, it is important to review CPT instructions for each category.

For further clarification of timed therapy codes or anesthesia related to obstetrical care, please reference the Highmark Provider Manual.