

## Payment Policy | Ophthalmology Examinations and Routine Eye Exams



**EFFECTIVE DATE:** 02|02|02

**POLICY LAST UPDATED:** 04|17|2018

### Overview:

The purpose of this policy is to describe coding guidelines for use of CPT codes 92002, 92004, 92012, 92014, 92015 and HCPCS II codes S0620 and S0621.

### Medical Criteria:

Not applicable

### Policy Statement:

**Blue CHiP for Medicare and Commercial Products:**

#### Members that have a standalone vision plan:

BCBSRI providers, who are also participating providers with the member's vision benefit plan, should follow the contractual and claims filing guidelines of the vision benefit plan. This includes, but is not limited to, filing claims for routine eye care services to the member's vision benefit plan.

#### For members that do not have a standalone vision plan:

A BCBSRI member who schedules an examination for the purpose of a routine eye exam or any eye exam with no specific medical complaint upon the scheduling of the exam/appointment shall be billed to BCBSRI as a routine eye exam under codes S0620 and S0621. The ultimate diagnosis of the patient's condition, as a result of the exam and/or identification of a pathological condition, does not change the coding. This includes services where a diagnosis and treatment plan have been initiated.

#### Medical Examinations and Evaluations with Initiation/Continuation of Diagnostic and Treatment Program:

CPT codes 92002-92014 are for medical examination and evaluation with initiation or continuation of a diagnostic and treatment program. The intermediate services (92002, 92012) describe an evaluation of a new or existing condition complicated with a new diagnostic or management problem with initiation of a diagnostic and treatment program. They include the provision of history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated, including mydriasis for ophthalmoscopy. The comprehensive services include a general examination of the complete visual system and always include initiation of diagnostic and treatment programs.

These services are valued in relationship to E/M services, though past Medicare fee schedule work relative value unit cross walks from ophthalmological services to E/M no longer exist. Nonetheless, the valuations provide some understanding of the type of medical decision-making (MDM) that might be expected. 92002 is closest to 99202 (low or moderate MDM) and 92004 is between 99203 and 99204 (moderate to high MDM). Code 92012 is closest to 99213 (low to moderate MDM) and 92014 is closest to 99214 (moderate to high MDM).

These services require that the patient needs and receives care for a condition other than refractive error.

They are not for screening/preventive eye examinations, prescription of lenses or monitoring of contact lenses for refractive error correction (i.e. other than bandage lenses or keratoconus lens therapy).

There must be initiation of treatment or a diagnostic plan for a comprehensive service to be reported. An intermediate service requires initiation or continuation of a diagnostic or treatment plan. Follow-up of a condition that does not require diagnosis or treatment does not constitute a service reported with 92002-92014. For example, care of a patient who has a history of self-limited allergic conjunctivitis controlled by OTC antihistamines who is being seen primarily for a preventive exam should not be reported using 92002-92014. A patient who has an early or incidentally identified cataract and is not being seen for visual disturbance related to the cataract, but is being seen primarily for refraction or screening, is not receiving a service reported with 92002-92014.

Medical examinations and evaluations with initiation/continuation of treatment or diagnostic programs for the treatment of disease are typically covered services without limitation. Ophthalmologic screening/preventive exams and exams for refractive error, commonly referred to as "Routine Eye Exams", are typically limited benefit services, e.g. one every 24 months. Glaucoma screening for high risk Medicare beneficiaries is covered once every 12 months and should be reported with HCPCSII code. An annual dilated eye examination for diabetics is considered a diagnostic treatment plan and is correctly reported with the most appropriate CPT code based upon the level of services.

Reporting screening, preventive or refractive error services with codes 92002-92014 is misrepresentation of the service, potentially to manipulate eligibility for benefits and is fraud. If the member has no coverage for a routine eye exam or lens services, it is appropriate to inform the member of their financial responsibility. Do not provide the member with a receipt for 92002-92014 if providing a non-covered preventive/screening Routine Eye Exam service as the member may seek clarification from BCBSRI and these services are typically covered.

NEW PATIENT- Same Specialty and Subspecialty:

CPT defines when a patient is new or established. It uses terms "exact same specialty" and "exact same subspecialty". CPT also states "When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician." BCBSRI uses American Boards of Medical Specialties or American Osteopathic Association Boards to define physician specialties. In some cases, BCBSRI creates additional specialties at our sole discretion. The team practice concept in the same group as defined for APRNs/PAs also could apply to other disciplines/licensure classes in reporting E/M. In general, if two or more disciplines may report E/M, it applies. For example, optometry and ophthalmology in the same group would be considered the exact same specialty/subspecialty. However, a clinical social worker and psychiatrist in the same group would not be so considered.

### **Routine Ophthalmological Evaluation, Including Refraction:**

HCPCS Codes S0620 and S0621 are used for these services for the new and established patient, respectively. If during the course of an evaluation it is necessary to initiate a treatment or diagnostic program, the appropriate CPT code (92002-92014) may be reported instead. A insignificant or trivial problem/abnormality that is encountered in the process of performing the routine examination and which does not require significant additional work would not warrant use of the CPT code.

The HCPCSII codes, S0620-S0621, direct the claim to be correctly adjudicated based upon the member's coverage for preventive and refraction exams. These services include screening for glaucoma or other eye disease consistent with the standards of care for a complete preventive eye examination.

In the instance where a patient is treated for a condition that would allow the reporting of 92002 or 92004, but the higher level (based upon allowance) service correctly reported is the Routine Exam, S0620-S0621 may be reported. In the case where a member does not have benefits for the routine exam, as verified with

BCBSRI members, the CPT should be reported and the member may be charged the difference between the charge for the non-covered routine service(s) and the charge (not allowance) for the covered service.

**Refraction:**

CPT 92015 describes refraction and any necessary prescription of lenses. Refraction is not separately reimbursed as part of a routine eye exam or as part of a medical examination and evaluation with treatment/diagnostic program.

**Payment and Coding Policy Enforcement:**

The enforcement of the directives in this policy do not involve medical necessity review. Limitations on recovery for incorrectly coded services may not apply as incorrect coding may be viewed as fraudulent reporting.

**Coverage:**

Typically, one routine eye exam is covered per calendar year if an optometrist or ophthalmologist performs the examination. Medically necessary eye examinations are covered. Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet for applicable vision care services.

**Coding:**

Medical examinations, and evaluations with initiation/continuation of diagnostic and treatment programs should be filed with the following codes:

- 92002** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
- 92004** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
- 92012** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
- 92014** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits

The following code is not separately reimbursed:

- 92015 Determination of refractive state

Routine ophthalmological evaluation (including refraction) should be filed with the following codes:

- S0620** Routine ophthalmological examination including refraction; new patient
- S0621** Routine ophthalmological examination including refraction; established patient

Diagnosis that will deny (attached)

**Related Medical Policies:**

None

**Publication:**

- Provider Update, May 2018
- Provider Update, September 2017
- Provider Update, August 2011

### References:

1. American Academy of Ophthalmology. Site referenced on 7/2/10: <http://www.aaopt.org/>.
2. The American Ophthalmological Society. Site referenced on 7/6/10: <http://www.aosonline.org/>.
3. The Foundation of the American Academy of Ophthalmology. Site referenced on 7/15/10: <http://www.eyecareamerica.org/eyecare/treatment/eye-exams.cfm>.
4. The International Council of Ophthalmology. Site referenced on 7/2/10: <http://www.icoph.org/about.html>

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