Medical Coverage Policy

Ophthalmology Examinations and Refractions: Correct Coding and Benefits Adjudication

☐ Device/Equipment ☐ Drug ☐ Medical ☐ Surgery ☐ Test ☒ Other

Effective Date:	10/01/11	Policy Last Updated:	2/15/2011

☐ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☒ **Prospective review is not required.**

Description:
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 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 99202-99214. 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 99202-99214.

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.

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-S0261, 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 a covered service as part of a covered Routine eye exam or as part of a covered medical examination and evaluation with treatment/diagnostic program. It is included in the BCBSRI allowance for those services. If it is part of a non-covered service (e.g. the member has no routine eye exam benefits), the payment policy bundling the exam does not apply.

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
92004
92012
92014

Routine ophthalmological evaluation (including refraction) should be filed the following codes:
S0620
S0621

Also known as:
Not applicable.

Related Medical Policies:
Not applicable

Publication:
Provider Update, August 2011

References:

American Academy of Ophthalmology. Site referenced on 7/2/10: http://www.aao.org/.

The American Ophthalmological Society. Site referenced on 7/6/10: http://www.aosonline.org/.

The Foundation of the American Academy of Ophthalmology. Site referenced on 7/15/10: http://www.eyecareamerica.org/eyecare/treatment/eye-exams.cfm.

The International Council of Ophthalmology. Site referenced on 7/2/10: http://www.icoph.org/about.html.

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