Reimbursement Policy:

Ophthalmology
(Commercial and Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20220027	EH: 9/30/2021 CCI: 2/01/2023	**RPC (Reimbursement Policy Committee)**

Overview: The purpose of this policy is to describe coding and reimbursement guidelines for use of CPT codes 92002, 92004, 92012, 92014, and 92015.

Policy Statement:

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 requires the 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 (See Documentation Guidelines). 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 appropriate HCPCS 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 EmblemHealth/ConnectiCare and these services are typically covered.

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.

Coverage:

Typically, one routine eye exam is covered per calendar year if an optometrist or ophthalmologist performs the examination up to age 20. Medically necessary eye examinations are covered. Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage or Member Benefit Agreement for more information

Applicable CPT Codes

CPT Code	Description
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

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CPT Code	Description
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
92015	Determination of refractive state

Documentation Guidelines:

Eye Visit Codes – Comprehensive (92004 and 92014)

To document a comprehensive eye visit code, you should first factor in the number of exam elements you performed.

These exam elements include:

1. Visual acuity
2. Gross visual fields
3. Extraocular motility
4. Conjunctiva
5. Ocular adnexa
6. Pupils and iris
7. Cornea, using a slit lamp
8. Anterior chamber, using a slit lamp
9. Lens
10. Intraocular pressure
11. Optic nerve discs
12. Retina and vessels; dilated unless contraindicated and documented in chart

In addition to the above, you need to document initiation of diagnostic and treatment program. However, to document "initiation of diagnostic and treatment program," you must have at least one of the following:

- Prescription of medication;
- Arrangement of special ophthalmological diagnostic or treatment services;
- Consultations;
- Laboratory procedures; or
- Radiological procedures

Note: Reporting a follow-up comprehensive service (92014) with the same diagnosis or condition of another

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comprehensive ophthalmologic service within six months' time may require submission of medical records.

Eye Visit Codes – Intermediate (92002 and 92012)

An intermediate exam consists of less than 12 elements. *If you have performed less than two exam elements, use an evaluation and management (E/M) Level Two service (99212).*

The intermediate exam eye visit codes require documentation of:

1. Chief complaint
2. History
3. General medical observation
4. Visual acuity
5. External ocular exam
6. Adnexal exam

You may also dilate in the intermediate exam when necessary.

References:

1. American Academy of Ophthalmology. http://www.aao.org/
2. The American Ophthalmological Society. http://www.aosonline.org/
3. The American Academy of Ophthalmology Foundation. http://www.eyecareamerica.org/eyecare/treatment/eye-exams.cfm
4. The International Council of Ophthalmology. http://www.icoph.org/about.html

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	9/8/2022	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number • ConnectiCare – New Policy
EmblemHealth	9/2021	• EH – New Policy