Clinical Policy: Medical Eye Examinations

Reference Number: OC.UM.CP.0041
Last Review Date: 12/2021

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Medical eye examinations are performed periodically to detect, diagnose, treat and monitor ocular diseases or visual dysfunctions. This policy describes the clinical indications for a medical ophthalmological examination.

Policy/Criteria

I. It is the policy of health plans affiliated with Envolve Vision, Inc.® (Envolve) that medical eye examinations are **medically necessary** for any of the following indications:

A. Signs, symptoms and/or history of ocular disease, pathology, degeneration, dystrophy or injury;

1. If a patient presents for a routine examination and during the course of the examination a medical diagnosis is discovered, the examination is still reported as routine. If a patient presents to a provider's office with a medical symptom (as reflected in the chief complaint), the examination is reported with the appropriate primary medical diagnosis in Items 21 and 24E of Form CMS-1500. If a patient's feared complaint is determined to be unfounded (no disease is present), the examination is reported as a medical evaluation with a diagnosis of Z71.1 (ICD 9:V65.5) (feared complaint unfounded).
2. Refractive diagnoses unaccompanied by complicating comorbidities will be interpreted as a routine ophthalmological examination including refraction. Diagnosis codes labeled "other specified" (e.g. other specified visual disturbances) or "unspecified" (e.g. subjective visual disturbance, unspecified) do not meet the requirements of a valid co-morbidity or medical reimbursement. Diagnosis codes that describe signs and symptoms (e.g. headache, pain in or around the eye, visual discomfort), as opposed to diagnosis, are suitable only when a diagnosis has not been established and do not meet requirements of a valid co-morbidity or medical reimbursement. *See clinical policy OC.UM.CP.0013 Preventive (Routine) Examination.*

B. Assessment of ocular causes of headache symptoms following primary care evaluation;

1. Eye examinations are often recommended following initial evaluation by a primary care physician to rule out or evaluate potential ocular or refractive conditions that may be causing the headache symptoms. Among all underlying etiologies, diseases of the eye are rarely a cause of headaches.

C. Evaluation of ocular findings in systemic diseases with the potential to affect ocular health, such as diabetes and hypertension, tumors or immunocompromising conditions.

1. *See OC.UM.CPG.0022 Diabetic Eye Examination*

Background

The coverage of services rendered by an eye care provider is dependent on the purpose of the examination (as reflected in the chief complaint) rather than on the ultimate diagnosis of the patient's condition. Regardless of final diagnosis, services for a patient who presents for an eye examination with no complaint (or for a patient who presents with the request of utilizing his/her routine vision benefit) must be reported as a routine eye examination with the applicable CPT / HCPCS codes within the patient's benefit.

The medical record should document the following elements for a comprehensive ophthalmological eye exam[1]:

- Test of entering visual acuity (does not include determination of refractive error)
- Gross visual field testing (e.g. by confrontation)
- Test of ocular motility including primary gaze alignment (e.g. by cover test)
- Gross inspection of bulbar and palpebral conjunctivae
- Examination of ocular adnexae including lids, lashes, lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
- Examination of pupils including shape, size, symmetry, direct and consensual reaction to light and evaluation for afferent pupillary defect
- Slit lamp examination of the corneas and tear film
- Slit lamp examination of the anterior chambers including depth, presence or absence of cells and/or flare
- Slit lamp evaluation of the iris, anterior vitreous and lenses including anterior and posterior capsule, cortex and nucleus, with noted anomalies
- Measurement of intraocular pressures (unless contraindicated)
- Complete ophthalmoscopic fundus examination through dilated pupils (unless contraindicated) of:
  - Optic discs including C/D ratio, general appearance (e.g., atrophy, cupping, tumor, elevation) and nerve fiber layer
  - Posterior pole, including macular vessels, and periphery
- Initiation of diagnostic and treatment programs. All aspects of the patient's health status and social situation should be considered in determining an appropriate course of action.

Intermediate exams are performed to periodically monitor the effectiveness of treatment and/or the progression of disease or dysfunction. New patients are denoted as patients who have not received any professional services from the physician or another physician of the exact same specialty and subspecialty in the same group practice within the past three years.

Based upon the history and examination findings, additional elements might be indicated to further evaluate an ocular structure or function. These are not routinely part of the comprehensive medical eye clinical evaluation. Specialized clinical evaluation may include but are not limited to the following:

- Monocular near-vision testing
- Potential acuity testing

[1] Envolve Vision recommends completion and documentation of these elements unless contraindicated, and documentation of the contraindication when applicable.

- Glare testing
- Contrast sensitivity testing
- Color-vision testing
- Testing of stereoacuity and fusion
- Testing of accommodation and convergence amplitudes
- Central visual field testing (Amsler Grid)
- Expanded evaluation of ocular motility and alignment in multiple fields of gaze
- Exophthalmometry
- Tear break up time
- Schirmer and ocular surface testing
- Corneal sensation
- Gonioscopy
- Functional evaluation of the nasolacrimal tear drainage system
- Extended indirect ophthalmoscopy with scleral indentation
- Contact lens stereoscopic biomicroscopy (e.g., Goldmann three-mirror lens)

Procedures which are included as part of a general ophthalmologic service (CPT codes 92002 – 92014, 92018-92019; 99201-99215) and may not be reported or billed separately include:

- Laser interferometry
- Potential acuity meter
- Keratometry
- Exophthalmometry
- Tonometry
- Transillumination
- Color vision testing (Ishihara)
- Corneal sensation
- Phacometry
- Tear film adequacy
- Schirmer's test
- Slit lamp (biomicroscopy)
- Fundus examination
- Retinoscopy
- Gross visual field testing (confrontation testing)
- History commensurate with the definition of "intermediate"
- General medical observation
- Glare Testing

Envolve has established minimum standards for practitioner documentation and maintenance of medical records including record content, record organization and maintaining confidentiality for all patient health information. These standards, at a minimum, include the following:

- Providers must keep accurate and complete records that are legible, complete, dated, timed, signed and authenticated in written or electronic form by the person responsible for providing the service, including but not limited to examination notes, imaging and

diagnostic tests, prescriptions, referrals, and operative notes. All examinations require the signature of the rendering provider with the following requirements:

- The signature must be a legible handwritten signature or initials; a reviewer must be able to determine whose signature is used
- Electronic signatures should contain dates and times and include printed statements, e.g., "electronically signed by" or "verified/reviewed by" the rendering provider's name and preferably a professional designation. The authorship related to the signature must be clearly defined in the record.
- Digitized signature – an electronic image of the rendering provider's handwritten signature reproduced in its identical form using a pen tablet.
- Stamped signatures are not acceptable.

- Records must be prepared in accordance with the Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA) Current Procedural Terminology (CPT®), applicable State Medicaid guidelines and applicable clinical policies.
  - Providers should fully and legibly document all services performed at each patient encounter.
  - Each page of the record, whether a paper or electronic document, must identify the patient and date of service.
  - Each service, whether an examination or diagnostic test, should include the medical necessity for the service and level of service, the findings or results, and any applicable interpretation and report as required by applicable documentation guidelines and applicable clinical policies.
  - Generic findings statements that do not provide details including level of severity and potential treatment plans based on the individual examination/test results are not sufficient. Each service performed, including each component of an eye examination, must be individually/separately documented and cannot be copied from a previous date of service. The record must clearly support the diagnosis(es), show the medical necessity of each service and medical necessity of the level of service provided.

According to the ICD-10-CM Official Guidelines for Coding and Reporting, diagnosis codes are to be used and reported at their highest number of characters available. ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail. A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the seventh character if applicable. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g. a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to

select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	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
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
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. (For services 75 minutes or longer, see Prolonged Services 99417)
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and

CPT® Codes	Description
	straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99417)

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template	09/2020	10/2020
Annual Review	12/2020	12/2020
Annual Review; Restructured content in Background; Updated References	12/2021	12/2021

References

1. Centers for Medicare and Medicaid Services (CMS), Medicare Carriers Manual, Part 3, Section 2320
2. Centers for Medicare and Medicaid Services (CMS), 1997 Documentation Guidelines for Evaluation and Management Services Title XVIII, Social Security Act, Section 1862(a)(1)(A)
3. American Academy of Ophthalmology (AAO) Preferred Practice Patterns Committee. Preferred Practice Pattern®-Guidelines. Comprehensive Adult Medical Eye Evaluation. San Francisco, CA: American Academy of Ophthalmology, 2020. Available at https://www.aao.org/preferred-practice-pattern/comprehensive-adult-medical-eye-evaluation-ppp
4. American Optometric Association (AOA) Evidence-Based Optometry Guidelines Development Group, Comprehensive Adult Eye and Vision Examination, St. Louis, MO, American Optometric Association, September 2015, https://www.aoa.org/AOA/Documents/Practice%20Management/Clinical%20Guidelines/EBO%20Guidelines/Comprehensive%20Adult%20Eye%20and%20Vision%20Exam.pdf
5. Centers for Medicare and Medicaid Services (CMS), Payment Integrity Manual 100-08, https://www.cms.gov/
6. American Medical Association (AMA) CPT ® Evaluation and management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356,

99417) Code and Guideline Changes, Copyright 2021, https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Vision, Inc., or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed

herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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