Payment Policy | Ophthalmology Examinations and Routine Eye Examinations

EFFECTIVE DATE: 01|01|2019
POLICY LAST REVIEWED: 03|06|2024

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

Medicare Advantage Plans and Commercial Products

Members that have a standalone vison plan:

Blue Cross & Blue Shield of Rhode Island (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:

Medicare Advantage Plans

The first claim processed by BCBSRI during a calendar year from an ophthalmologist or optometrist reported with codes 92002-92014, S0620 or S0621 will be considered a routine eye exam (regardless of the diagnosis reported on the claim) for benefit application purposes. Please note that routine eye exam benefits are generally limited to one exam per year. Please check the member's specific benefits for details.

Any subsequent claims (regardless of diagnosis) processed during the calendar year filed with codes 92002-92014 shall be considered a medical specialist visit for purposes of benefit application.

All services reported under 99000's series Evaluation and Management codes e.g. 99213 during the calendar year, filed by an ophthalmologist or optometrist will be considered a medical specialist visit for purposes of benefit application.

Commercial:

Examinations scheduled for the purpose of a routine eye exam or any eye exam with no specific medical complaint upon the scheduling of the exam/appointment, should be billed to BCBSRI as a routine eye exam using HCPCS codes S0620 and S0621. The diagnosis of the patient's condition, as a result of the exam and/or identification of a pathological condition, does not change the coding instructions above. This includes services where a diagnosis and treatment plan have been initiated.

Medicare Advantage Plans and Commercial Products

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 or without 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.

Background

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 (92004, 92014) services include a general examination of the complete visual system and always include initiation of diagnostic and treatment programs. 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.

These services require that the patient needs and receives care for a condition other than refractive error and screening services generally related to a routine exam. 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).

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. 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. When scheduling a member for an annual diabetic exam, it should be made clear to the patient that the exam is not a routine eye care visit and that the member’s benefit for a medical eye exam will be applied.

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. 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/routine eye 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 case where a member does not have benefits for the routine exam as verified with BCBSRI members and the reason for the scheduled exam was a routine exam, and the member receives initiation and treatment or a diagnostic program treatment during the visit a CPT should be reported and such service shall follow the member's benefit for a medical eye exam.

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
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
Medicare Advantage Plans
The following codes are covered according to the policy statement

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

The following code is not separately reimbursed:
92015 Determination of refractive state

Commercial Products
Routine Eye Examination
The following CPT codes for a Routine ophthalmological evaluation (including refraction) are covered when filed with one of the following codes:
S0620 Routine ophthalmological examination including refraction; new patient
S0621 Routine ophthalmological examination including refraction; established patient

The following code is not separately reimbursed:
92015 Determination of refractive state

Medical Eye Examination (non-routine)
The following CPT codes for medical examinations, and evaluations with initiation/continuation of diagnostic and treatment programs are covered when filed with one of the following CPT codes:

Note: Claims filed with one of the following CPT codes and a routine diagnosis code on the attached spreadsheet will deny as invalid for service

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

Routine Eye Diagnosis

Related Medical Policies:

None

Publication:

Provider Update, May 2021
Provider Update, April 2019
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.aao.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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