WellCare
Beyond Healthcare. A Better You.

Applicable To:
- ☑ Medicare
- ☑ Medicaid

Claims Payment Policy: Frequency of Comprehensive Ophthalmological Exams- IH062/LT062

Policy Number: CPP-151

BACKGROUND

Per CPT® guidelines, comprehensive ophthalmological services "describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes biomicroscopy, examination with cycloplegia or mydriasis, and tonometry. It always includes initiation of diagnostic and treatment programs".

POSITION STATEMENT

In accordance with clinical practice guidelines outlined by the American Academy of Ophthalmology (AAO) and American Osteopathic Association (AOA), WellCare will only reimburse for an intermediate, established patient ophthalmologic services when billed within six months of a previous comprehensive ophthalmologic service for review of the same condition. Should two comprehensive exams be required, it should be documented as such within the medical record and provided with the appeal.

Overview of WellCare's Comprehensive Ophthalmological Program

Wellcare will not reimburse comprehensive exams more than once in a six month period for review of the same medical condition. Medical eye exams may be considered medical necessary only when a disease condition of the eye is found or reasonably suspected. The medical record must clearly document the specific condition or the high risk medication.

The provider must perform all 12 required elements in order to bill for a comprehensive exam, unless contraindicated by patient age or trauma. If one of these factors keeps the provider from performing an element, the provider should document it in the chart.

The 12 required elements are as follows:

1. Test visual acuity (does not include determination of refractive error)
2. Gross visual field testing by confrontation

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3. Test ocular motility including primary gaze alignment
4. Inspection of bulbar and palpebral conjunctivae
5. Examination of ocular adnexa including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
6. Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoric) and morphology
7. Slit lamp examination of the corneas including epithelium, stroma, and endothelium and tear film.
8. Slit lamp examination of the anterior chambers including depth, cells and flare
9. Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex and nucleus
10. Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)
11. Ophthalmoscopic examination through dilated pupils (unless contraindicated) of optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer
12. Ophthalmoscopic examination through dilated pupils (unless contraindicated) of posterior segments including retina and vessels (eg, exudates and hemorrhages)

Billing a comprehensive exam also requires providers to initiate or continue a diagnostic and treatment program. According to CPT language, initiation of the program includes “the prescription of medication, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.” Medical record documentation must clearly indicate rationale which supports the medical necessity for performing each test. Documentation should also reflect how the test results were used in the patient’s plan of care.

The CPT definition also states that these codes can describe an examination that occurs on "one or more visits." The physician can complete an examination over more than one visits in a day (morning and afternoon) or more than one day (start today, complete the examination tomorrow). Although multiple visits are performed, only one visit is considered medically necessary.

Comprehensive ophthalmological exams should not be used for checkups when there’s a chronic problem being followed up every few weeks or months.

Pre Pay Review

Comprehensive ophthalmological exams should not be used for checkups when there’s a chronic problem being followed up every few weeks or months. If a patient is seen for a follow up visit within 6 months of the comprehensive ophthalmologic service (CPT 92014) performed for the same condition, the claim will be down coded to the Intermediate Ophthalmological (CPT 92012) service. Providers may see the following Explanation Codes on the Explanation of Payment (EOP) if this type of down coding is performed:

- IH062- E & M Code Level Denied based on info supplied on claim
- LT062- CPT recoded based on claim info. Medical Records needed.

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If the provider does not agree with a payment determination, the provider has the right to file a grievance by submitting the portion of the medical record that supports additional reimbursement. WellCare will review the submitted medical record(s) to assess the intensity of service and complexity of medical decision-making for the Ophthalmological services provided.

Dispute Process

If the provider does not agree with a payment determination, the provider has the right to file a dispute by submitting the medical record that supports additional reimbursement. WellCare will review the submitted medical record(s) to assess the intensity of service and complexity of medical decision-making for the services provided.

Providers will have dispute rights on recoded Comprehensive Ophthalmological Exams. For reason codes LTXXX, please submit disputes to WellCare Health Plans, ATTN: CCR, P.O. Box 31394 Tampa, FL 33631-3394. Please refer to WellCare's Quick Reference Guide (QRG) for additional instructions.

CODING & BILLING

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

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

DEFINITIONS

Ophthalmology	Ophthalmology is a branch of medicine and surgery which deals with the diagnosis and treatment of eye disorders. An ophthalmologist is a specialist in ophthalmology.

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Gross Visual Field Test	A visual field test is a method of measuring an individual's entire scope of vision, that is their central and peripheral (side) vision. Visual field testing maps the visual fields of each eye individually and can detect blind spots (scotomas) as well as more subtle areas of dim vision.
Scotomas	A scotoma is an area of partial alteration in the field of vision consisting of a partially diminished or entirely degenerated visual acuity that is surrounded by a field of normal – or relatively well-preserved – vision.
Basic Sensorimotor Examination	A basic sensorimotor exam evaluates ocular range of motion to determine if the eyes move together in the various cardinal positions of gaze (12:00, 1:30, 3:30, etc). This exam element is commonly noted as ocular motility, or extraocular muscles (EOM).
Biomicroscopy	The microscopic examination and study of living cells and tissues; specifically the examination of the living eye with the biomicroscope.
Cycloplegia	Paralysis of the ciliary muscle of the eye.
Mydriasis	Dilation of the pupil of the eye.
Tonometry	The measuring of intraocular pressure by determining the resistance of the eyeball to indentation by an applied force.

REFERENCES

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1. American Medical Association Current Procedural Terminology (CPT®) and associated publications and services 2020.
2. AOA Optometric Clinical Practice Guidelines. American Optometric Association. Retrieved February 14, 2020 from https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines
3. 5 Tips for Billing Comprehensive Eye Visit Exams. American Academy of Ophthalmology. Retrieved February 14, 2020 from: https://www.aao.org/young-ophthalmologists/yo-info/article/5-tips-for-billing-comprehensive-eye-visit-exams

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
04/03/2020	• Approved by RGC