Policy Name	Clinical Policy – Extended Ophthalmoscopy
Policy Number	1335.00
Department	Clinical Product & Strategy
Subcategory	Medical Management
Original Approval Date	03/08/2019
Current MPC/CCO Approval Date	07/12/2023
Current Effective Date	10/01/2023

Company Entities Supported (Select All that Apply)
_X_Superior Vision Benefit Management
_X_Superior Vision Services
_X_Superior Vision of New Jersey, Inc.
_X_Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
_X_ Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company'

ACRONYMS or DEFINITIONS	
n/a	

PURPOSE

To provide the medical necessity criteria to support the indication(s) for extended ophthalmoscopy procedures and to render medical necessity determinations. Applicable procedure codes are also defined.

POLICY

A. BACKGROUND

Extended ophthalmoscopy is the detailed examination of the retina and/or the optic nerve in cases of serious disease or injury and always includes a drawing of the fundus and associated structures (vitreous, blood vessels, optic nerve) with interpretation and report. It is most frequently performed utilizing a 20 or 78 diopter lens, although it may be performed using contact lens biomicroscopy. It may require scleral depression and is customarily performed with the pupil dilated unless medically contraindicated. It is only performed by a physician when a more detailed examination (including the periphery) is needed following

routine direct or indirect ophthalmoscopy. The examination must be used in the medical decision making for the patient.

B. Medically Necessary

Medical necessity may be established for diagnostic testing by defining the pertinent signs, symptoms, or medical history of a condition which requires further information.

1. Extended ophthalmoscopy may be medically necessary when the information garnered from an eye exam, including routine ophthalmoscopy, is insufficient to assess the patient's disease.

2. Extended ophthalmoscopy may be medically indicated to evaluate injuries, abnormalities, or disease in the fundus, choroid or related structures. Pathology must be present to warrant a drawing, thus verifying medical necessity.

3. The initial extended ophthalmoscopy must be completed for each eye. Subsequent extended ophthalmoscopy may be medically necessary for re-evaluation of disease progression. A retinal drawing is only necessary when there is pathology, and for subsequent extended ophthalmoscopy when there is a clinically significant change in the condition previously drawn or a new condition.

C. Not Medically Necessary

Extended ophthalmoscopy may not be indicated in the following situations:

1. Extended ophthalmoscopy on an eye without signs, symptoms, serious disease or abnormalities on routine direct or indirect ophthalmoscopic exam.

2. Repeated extended ophthalmoscopy, at each visit, without a clinically significant change in signs, symptoms, disease, or condition.

3. No retinal drawing, with sufficient detail, of a serious disease or abnormality.

4. Extended ophthalmoscopy performed during the global surgery period of an ophthalmic surgical procedure to verify the expected outcome. For example, extended ophthalmoscopy after laser repair of retinal detachment to ascertain if it has been a successful procedure should not be billed as it is an incidental part of postoperative care.

5. Extended ophthalmoscopy without a documented medical rationale in the medical record.

6. When other related ophthalmological tests (e.g., fundus photography, angiography, ultrasound, optical coherence tomography, etc.) have been performed, extended ophthalmoscopy will be denied as not medically necessary unless it provided additive (non-duplicative) information. For example, reimbursement would not be made for

extended ophthalmoscopy with optic disc drawing after a fundus photograph of the optic disc for a patient with glaucoma.

D. Documentation

Medical necessity is supported by adequate and complete documentation in the patient's medical record that describes the procedure and the medical rationale for it. Documentation requires at a minimum all the following items, which must be available upon request to initiate or sustain previous payments. For retrospective reviews the full operative report and medical plan of care is required.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service). Services provided/ordered must be authenticated by the physician. The method used shall be handwritten or electronic signature. Stamped signatures are not acceptable.

1. The patient's medical record must contain documentation that supports the medical necessity for extended ophthalmoscopy for each eye. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. All findings, including longitudinal analysis on subsequent extended ophthalmoscopy, and a plan of action should be documented in the patient's medical record supporting the medical necessity for the extended ophthalmoscopy.
2. There must be a separate retinal drawing with sufficient detail that a longitudinal study could be performed. (Retina to periphery or optic nerve margin). Detailed drawings are large (at least 3 inches), scaled, labeled, and usually in medically appropriate color(s). Drawings may not contain preprinted anatomical landmarks. Clock hours may be preprinted for the sake of improved accuracy. Zones may be preprinted for pediatric cases such as retinopathy of prematurity.
3. Optic nerve abnormalities should be documented in a separate drawing from any in the retina. For example: cupping, disc rim, pallor and slope of any pathology surrounding the optic nerve.
4. Documentation in the patient's medical record for a diagnosis of glaucoma must include all the following: Documentation of the specific method of examination (e.g., lens, scleral depression, instrument used) should be maintained in the medical record.
5. Documentation to support the monitoring of neurotoxicity or retinal toxicity associated with certain medications (e.g., hydroxychloroquine), as indicated with the primary diagnosis code Z79.899, long term (current) drug therapy.
6. The medical record should document whether the pupil was dilated for the exam.
7. Subsequent extended ophthalmoscopy must demonstrate a clinically significant difference from the prior extended ophthalmoscopy and not simply replicate it.

E. Procedural Detail

CPT Codes	
92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
Invalid Modifiers	
L, R, Bilateral	Procedure is inherently bilateral.
TC, 26	No technical component of extended ophthalmoscopy
58, 78, 79	Not a surgical service

DISCLAIMER and COPYRIGHTS

This clinical policy is provided for information purposes only and does not constitute medical advice. Versant Health, Inc. and its affiliates (the "Company") do not provide health care services and cannot guarantee any results or outcomes. Treating doctors are solely responsible for determining what services or treatments to provide to their patients. Patients (members) should always consult their doctor before making any decisions about medical care.

Subject to applicable law, compliance with this clinical policy is not a guarantee of coverage or payment. Coverage is based on the terms of an individual's benefit plan document, which may not cover the service(s) or procedure(s) addressed in this clinical policy. The terms of the individual's specific benefit plan are always determinative. Every effort has been made to ensure that the information in this clinical policy is accurate and complete, however the Company does not guarantee that there are no errors in this policy or that the display of this file on a website is without error. The company and its employees are not liable for any errors, omissions, or other inaccuracies in the information, product, or processes disclosed herein. Neither the Company nor the employees represent that use of such information, products, or processes will infringe on privately owned rights. In no event shall the Company be liable for direct, indirect, special, incidental, or consequential damages arising out of the use of such information, product, or process.

COMPANY'S COPYRIGHT STATEMENT

AMA COPYRIGHT STATEMENT

RELATED POLICIES AND PROCEDURES	
n/a	

DOCUMENT HISTORY		
Approval Date	***Revisions***	***Effective Date***
03/08/2019	Initial policy	03/08/2019
12/18/2019	Annual review; no criteria changes; CMS required code replacements.	01/01/2020
10/28/2020	Annual review; Clarified definitions (A.); added indication for long term therapeutic drug monitoring.	03/01/2021
10/06/2021	Annual review; no criteria changes.	04/01/2022 (superseded)
01/05/2022	Administrative update to correct listed modifiers	02/01/2022
07/06/2022	Annual review; no criteria changes	10/01/2022
07/12/2023	Annual review; no criteria changes	10/01/2023

REFERENCES AND SOURCES

1. Bakker E, Dikland FA, van Bakel R, et al. Adaptive optics ophthalmoscopy: a systematic review of vascular biomarkers. Surv Ophthalmol. 2022 Mar-Apr;67(2):369-387. doi: 10.1016/j.survophthal.2021.05.012. Epub 2021 Jun 6. PMID: 34090882.
2. Bresnick GH, Mukaamel DB, Dickinson JC, et.al. A screening approach to the surveillance of patients with diabetes for the presence of vision-threatening retinopathy. *Ophthalmology*. 2000; 107:19-24.
3. Fischer J, Otto T, Delori F, et al. Scanning Laser Ophthalmoscopy (SLO). 2019 Aug 14. In: Bille JF, editor. High Resolution Imaging in Microscopy and Ophthalmology: New Frontiers in Biomedical Optics [Internet]. Cham (CH): Springer; 2019. Chapter 2. PMID: 32091845.

4. Hartley MJ, Bartley GB. Ophthalmology and Direct Ophthalmoscopy in Contemporary Medical Education. Am J Ophthalmol. 2022 Jun;238: xv-xvi. doi: 10.1016/j.ajo.2022.02.004. Epub 2022 Feb 19. PMID: 35192792.
5. Schneiderman H. The Funduscopic Examination. In: Walker HK, Hall WD, Hurst JW, eds. *Clinical Methods: The History, Physical, and Laboratory Examinations*. 3rd ed. Boston: Butterworths; 1990.
6. Uhr JH, Obeid A, Wibbelsman TD, et.al. Delayed Retinal Breaks and Detachments after Acute Posterior Vitreous Detachment. Ophthalmology. 2020 Apr;127(4):516-522. doi: 10.1016/j.ophtha.2019.10.020. Epub 2019 Oct 23. PMID: 31767432.

SOURCES

1. AAO PPP Retina/Vitreous Committee, Hoskins Center for Quality Eye Care, 2019.
2. Opt Med. Ditch the Ophthalmoscope. https://forms.optomed.com/ditchtheophthalmoscope . Accessed 5/2023.
3. Documentation and drawing in Ophthalmology, 2021. https://www.eophtha.com/posts/documentation-drawing-in-ophthalmology. Accessed 5/2023.
4. Stanford Medicine. Introduction to the fundoscopic / ophthalmoscopic exam. https://stanfordmedicine25.stanford.edu/the25/fundoscopic.html. Accessed 5/5023.