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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 criteria to support the indication(s) for routine and medical eye exams. Applicable procedure codes are also defined.

POLICY

A. Background

Eye exams are divided into two groups:

1. Medical – the eye exam is performed for the diagnosis and/or treatment of disease or injury or to improve the eye's function.

2. Routine and Vision (Refractive) – the eye exam is performed to screen for disease in an otherwise healthy patient without history of eye disease or visual complaints and to address ametropias and provide corrective lenses if necessary. If follow-up evaluation and management is needed due to a detected medical condition, the subsequent visit

and treatment is classified as a medical exam and is generally described by the evaluation and management code set.

B. Medical Necessity

The medical necessity of an eye exam may be determined from the patient's chief complaint and the corresponding diagnosis. The stated reason for the appointment is not necessarily the purpose of the eye exam. Additional diagnoses, if any, are relevant for determining the level of service but do not change the purpose of the eye exam.

The frequency of ocular examinations should be based on the presence of visual abnormalities and the probability of visual abnormalities developing. Individuals who have ocular symptoms require prompt examinations. Individuals who do not have symptoms but who are at elevated risk of developing ocular abnormalities related to systemic diseases, such as diabetes mellitus and hypertension or who have a family history of eye disease, require periodic comprehensive eye examinations to prevent or minimize visual loss. Adults who have no symptoms, and who are at minimal risk, should receive an initial comprehensive eye examination and follow a schedule of periodic assessment designed to detect ocular disease.

C. 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 and, at a minimum, the following items. If a subsequent medical review audit is necessary, these items are expected to be available. For any retrospective review, a full operative report and/or plan of care is needed.

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 author. The method used shall be handwritten or electronic signature. Stamped signatures are not acceptable

The required documentation for eye exams include the following:

1. Chief complaint and history: The clinical notes and charted history reflect the nature of the presenting problem(s) and generate the differential diagnosis process.

2. The ocular examination and notes will include some or all the following elements depending upon the patient's complaint and condition:

    a. Visual acuity (VA)
    b. Confrontation visual field (CVF)
    c. Ocular motility (EOMs)
    d. Adnexa and eyelids
    e. Conjunctiva
    f. Cornea
    g. Anterior chamber
    h. Pupils

i. Iris
j. Lens
k. Intraocular pressure (IOP)
l. Fundus (discs, retina, macula, vessels, vitreous) including mydriasis, as indicated.
m. Mental status
n. Impression and plan for treatment or additional services

D. Procedural Detail

1. CPT (Current Procedural Terminology) defines codes 92004 and 92014 as *"one or more visits."* These procedure codes describe a single service that need not be performed in one session. It is possible to bridge a comprehensive exam over more than one session in a day (morning and afternoon) or more than one day. For bridged visits, one claim plus the medical record would reflect the fact that the exam extended over time. The span of time should be short, usually no more than a day or two, and billed when the service is completed. Bridged exams do not apply to E/M services or intermediate eye exams.

2. E/M codes 92002 – 92014 are on both the medical and routine exam lists. The diagnosis code determines whether the exam is medical or routine.

3. The screening exam (99173) is a component of both medical and routine/vision exams and is never a standalone service when performed by an ophthalmologist or optometrist.

E. CPT Codes for Routine and Medical Exams

Routine refractive exams	
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
G0466	Federally qualified health center (FQHC) visit, new patient (for Medicare primary plans only)
G0467	Federally qualified health center (FQHC) visit, established patient (for Medicare primary plans only)
S0620	Routine ophthalmological examination including refraction; new patient
S0621	Routine ophthalmological examination including refraction; established patient

T1015	Clinic visit/encounter, all-inclusive for FQHC use

Medical exams	
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 straight forward medical decision making. When using time for code selection, 15 minutes total time met or exceeded 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 minutes total time met or exceeded 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, 45minutes total time met or exceeded 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, 60minutes total time met or exceeded is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, which may not require 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 straightforward medical decision making. When using time for code selection, 10 minutes total time met or exceeded 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 minutes total time met or exceeded 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 minutes total time met or exceeded 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, 40minutes total time met or exceeded is spent on the date of the encounter.
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components . . . problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components . . . problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components . . . problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components . . . the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components . . . patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components . . . patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components . . . presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components . . . the presenting problem(s) are of low to moderate severity.

99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components . . . the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of patient, which requires these 3 key components . . . presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components . . . Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components . . . Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components . . . the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components . . . the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components . . . patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components . . . patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components . . . patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components . . . patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.

99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.
99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components . . . patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.
99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99342	Home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99343	Home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components . . . presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history . . . patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family
99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components . . . patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
G0466	Federally qualified health center (FQHC) visit, new patient (only allowed to be used with Medicare as primary.
G0467	Federally qualified health center (FQHC) visit, established patient (only allowed to be used with Medicare as primary)
T1015	Clinic visit/encounter, all-inclusive for FQHC use

Valid modifiers	
24	Unrelated Evaluation and a Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
57	Decision for surgery. Used on an evaluation and management service that resulted in the initial decision to perform surgery for those procedures that have a global period of 90 days or greater.
Invalid modifiers	
TC	Used when the physician performs the test but does not do the interpretation
26	Used to indicate the professional component of the service being billed was “interpretation only”

58	Performance of a procedure or service during the postoperative period was either planned prospectively at the time of the original procedure
78	Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the post-operative period
79	Unrelated procedure or service by the same physician during the postoperative period

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RELATED POLICIES	
1336	Telemedicine

DOCUMENT HISTORY		
Approval Date	***Revision***	***Effective Date***
02/06/2018	Initial Policy	02/06/2018
12/12/2018	Revision with technical /administrative amendments	12/12/2018
03/13/2019	Updated references	03/13/2019
12/18/2019	Updated format: expanded eye exam E/M and diagnosis codes and categorized into routine and medical. No criteria change.	01/01/2020
10/29/2020	Annual review; no criteria changes.	03/01/2021
04/07/2021	Removed CMS deleted code 99201	07/01/2021
7/11/2021	Added explicit exclusion of screening exam as a billable service on same day as a routine or medical eye exam.	11/01/2021
04/06/2022	Annual review; no criteria changes.	05/01/2022
04/12/2023	Annual review; no criteria changes.	06/01/2023
04/03/2024	Clarified that routine vs. medical status of an eye exam is determined by the patient's chief complaint; clarified that fundus exam is included in eye exam when indicated and is not a required component.	06/01/2024

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