REIMBURSEMENT POLICY

Optometric/Optical Services

Active

Policy Number: General Coding – 028
Policy Title: Optometric/Optical Services
Section: General Coding
Effective Date: 11/29/17

Description

Blue Cross coding policy follows the CPT system of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and optometrists.

Definitions

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

92015 Determination of refractive state

99202-99205 New patient evaluation and management (E/M) services

99211-99215 Established patient evaluation and management (E/M) services

Policy Statement

Both E/M codes and ophthalmology codes 92002, 92004, 92012, 92014, and 92015, may be appropriate to use by optometrists or ophthalmologists. The level of E/M service or the selection of ophthalmology codes must appropriately reflect the medical condition, the medical necessity, the tests performed, and be documented in the medical record. Selection of either an E/M code or an ophthalmology code may be appropriate for routine or medical diagnoses and should be based on the CPT definitions of services provided. Details of the patient encounter, as recorded on the patient medical record, must meet or exceed the stated CPT requirements to qualify for the code selected.

Blue Cross requires that all medical services be performed by the professionals eligible and credentialed to perform the service. The diagnosis and CPT coding must appropriately reflect the medical condition and that the medical record reflect the medical necessity and severity of the condition.

Charges for Lenses and Contact Lens Fitting
Submit charges for any type of lenses using Level II HCPCS codes. Any fee for fitting and prescription of contact lenses may be reported by submitting a CPT code from the contact lens services section in addition to the contact lens supply code. The fee for fitting and prescription of contact lenses may also be included in the contact lens charge.

Eyewear billing and Reimbursement
Participating providers are required to submit claims and will receive payment for subscriber's who have an eyewear benefit.

If you bill eyewear for a subscriber, you should bill the eyewear on a separate claim form from the one used for the eye exam. Use your optician's NPI when billing for the eyewear. Your optometrist's contracting NPI should be submitted when billing for the eye exam. Blue Cross requires that eye exams and eyewear claims be billed on separate claim forms.

Pediatric Eyewear Benefit
Individual and small group products sold on or off the exchange must include ten essential health care benefits (EHB). One of the EHB's is for corrective lenses for children age 18 and younger. The benefit provides a maximum of: one (1) frame and one (1) pair of lenses; or, one (1) pair of contact lenses; or, one (1) year supply of disposable contact lenses per calendar year. Payment will be in accordance with the provider's Aware agreement, and the benefit is subject to the subscriber's deductible and coinsurance for the plan. Providers shall identify a collection of frames from which subscribers shall choose. The collection shall include Ray-Ban brand frames and Disney brand frames, or frames that are substantially similar. The allowed amount for frames is the lesser of cost or $130. If a subscriber chooses more expensive frames, there will be no benefit. The subscriber may not purchase more expensive frames and be billed for the difference. Eyewear claims will be paid to the provider.

Platinum Blue
We will pay the provider for Medicare eligible eyewear claims based on contract benefits; participating Platinum Blue providers are required to submit these claims to us on behalf of the subscriber. For non-Medicare covered eyewear claims only, payment will be made to the subscriber if the claim was submitted by the subscriber; providers are not required to submit these claims on behalf of the subscriber.

Routine Vision Services
Routine vision services may be allowed without a referral. However, if an illness or problem is discovered, treatment requires a referral from the patient's primary care clinic.

Vision Therapy Services
Blue Cross will reimburse the initial visit under 92060. Visual therapy instruction by any method that is provided during the first visit is included in this description. Separate billing for CPT code 92065 will not be allowed for the initial visit. Vision therapy services involve non-surgical orthoptics, medical, or sensory motor re-education for patients who suffer from conditions such as strabismus, amblyopia, exotropia, and/or esotropia.

All subsequent visits for patient evaluation and monitoring of treatment will be billed to Blue Cross under CPT code 92065. Office calls (99202-99205, 99211-99215, 92002-92014) and sensorimotor exams (92060) are not eligible for separate billing from the providers of the visual therapy during treatment unless a medical examination is clinically indicated for other reasons.

Claims Filing Requirements
Use CPT codes or HCPCS level II code to bill your services. ICD-10-CM codes should be used to submit an appropriate diagnosis for your patient. Please note the correct diagnosis codes for routine vision care is Z01.00 or H52.00-H52.7 (ICD-10-CM codes) extended to the appropriate fourth, fifth or sixth digits.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Services are reimbursed under the subscriber's vision/medical benefits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A
ICD Diagnosis:	Z01.00, H52.00 - H52.7
ICD Procedure:	N/A
HCPCS:	92002 – 92015, 92060, 92065, 99202 – 99205, 99211-9915
Revenue Codes:	N/A
Deleted Codes:	99201

Policy History

Initial Committee Approval Date:	November 29, 2017
Code Update:	January 26, 2021
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Cross Reference:	N/A

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