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1.0 Description of the Procedure, Product, or Service

General ophthalmological services include a medical examination and evaluation with the initiation or continuation of a diagnostic and treatment program. According to the American Academy of Ophthalmology 2007-Preferred Practice Pattern Guidelines for Pediatric Eye Evaluations, indications for a pediatric ophthalmic evaluation include:

- a. Risk factors-general health problems, systemic disease, or use of medications that are known to be associated with eye disease and visual abnormalities;
- b. A family history of conditions that cause or are associated with eye or vision problems; or
- c. Signs or symptoms of eye problems by history or observations by family members.

1.1 Definitions

General ophthalmologic services include the following definitions for the two levels of service:

- a. **Intermediate ophthalmological services** are an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable.
- b. **Comprehensive ophthalmological services** are a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NC Health Choice (NCHC) recipients shall be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

NCHC covers general ophthalmological services for new or established recipients (patients) when the level of service includes several routine optometric/ophthalmologic examination techniques that are integrated with the diagnostic evaluation. Refer to **Subsection 5.2** for services that are included in the diagnostic evaluation.

Intermediate level of service includes all of the following:

- a. medical history and observations;
- b. external ocular and adnexal examination; and
- c. other diagnostic procedures as indicated.

Comprehensive level of service includes all of the following:

- a. medical history and observations;
- b. external and ophthalmoscopic examinations
- c. gross visual fields;
- d. basic sensorimotor examination; and
- e. initiation of diagnostic and treatment programs consisting of:
 1. the prescription of medication;
 2. arranging for special ophthalmological diagnostic or treatment services;
 3. consultations;
 4. laboratory procedures; or
 5. radiological services.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

NCHC does not cover general ophthalmological services when the criteria in **Subsection 3.2** are not met and for any one of the following:

- a. screening, preventative or refractive error services (routine eye exams);
- b. prescription of lenses;
- c. monitoring contact lenses for refractive error correction; or
- d. follow-up of a condition that does not require diagnosis or treatment.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is not required for General Ophthalmological Services.

5.2 Limitations

- a. General ophthalmological services are integrated services in which medical decision making is not separate from the examining techniques used. The following service components are included as part of general ophthalmologic services and must not be billed separately:
 1. slit lamp examination;
 2. keratometry;
 3. ophthalmoscopy;
 4. retinoscopy;
 5. tonometry; and
 6. motor evaluation.

- b. Intermediate and comprehensive ophthalmological services for established recipients (patients) are each limited to 2 times per year.

5.3 Evaluation and Management Services

Refer to **Attachment A (C) Procedure Codes**.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
7/1/2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
12/15/2011	Throughout	To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 1T-1 under Session Law 2011-145 § 10.41.(b)

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Codes	Description
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 service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program comprehensive, established patient, 1 or more visits

Evaluation and Management (E/M) visit codes (CPT 99201-99215) must not be billed on the same date of service as CPT codes for general ophthalmological services. Evaluation and management codes may be more appropriate if there are many eye problems, if counseling and coordination of care dominates the visit, or if an underlying medical condition is the primary reason for the visit. The ophthalmology codes are more specific to the services and examination rendered during a visit related to the ocular system. The code choice is dependent on the specific services provided to the recipient. The code that most accurately describes the services performed must be the code reported.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

General ophthalmological services are comprised of integrated services and are billed with one unit per complete examination even if performed over more than one session.

F. Place of Service

Inpatient, outpatient, office

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services

H. Reimbursement

Providers shall bill their usual and customary charges.