Medicare Ophthalmology Guidelines

Medicare may cover some vision costs if they are associated with other covered expenses (i.e. eye problems that result from an illness or injury could be covered).

Eye glasses, contact lenses, and routine eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions (i.e. 92015) by whatever practitioner and for whatever purpose performed; are not covered.

Provider Definitions

Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

Effective April 1, 1987, a doctor of optometry is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation. To be covered under Medicare, the services must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

Optometry Visits

Ophthalmologists and Optometrists have two types of office visit codes to choose from: Eye codes (92XXX) and E&M codes (99XXX).

The documentation requirement for each code set varies, but they both share the same general principles. Medical record documentation is required to record pertinent facts, findings and observations about the patient’s health history, examinations, tests, treatments and outcomes. The correct code for a particular visit depends on the documented elements of an exam, the seriousness of the patient’s condition and the extent of the history.

New versus established patient guidelines are the same for both Eye and E&M codes. A new patient is defined as one who, within the previous three years, has not received professional services from a physician or another physician of the same specialty belonging to the same group practice.

Documentation of exams follows the classic SOAP note (subjective, objective, assessment and plan). The quality and quantity of the documentation determines the level of the exam. While chart forms may vary, they must include the following elements:

- Patient's name, date of exam
- Subjective
  - Chief complaint
  - History (current illness, medical, family, social)
- Objective
  - Exam
- Assessment
  - Impression, diagnosis, progress
Plan
- Orders, Rx, treatment, options, instructions, referral
- Physician’s signature.

Optometry visits must follow the CMS general principals of medical record documentation guidelines, either the 1995 or 1997 version:


Non-Covered Diagnosis Codes:

The following diagnoses are used to indicate a routine eye exam.

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>367.0</td>
<td>Hypermetropia</td>
</tr>
<tr>
<td>367.1</td>
<td>Myopia</td>
</tr>
<tr>
<td>367.20</td>
<td>Astigmatism Unspecified</td>
</tr>
<tr>
<td>367.21</td>
<td>Regular Astigmatism</td>
</tr>
<tr>
<td>367.22</td>
<td>Irregular Astigmatism</td>
</tr>
<tr>
<td>367.31</td>
<td>Anisometropia</td>
</tr>
<tr>
<td>367.32</td>
<td>Aniseikonia</td>
</tr>
<tr>
<td>367.4</td>
<td>Presbyopia</td>
</tr>
<tr>
<td>367.51</td>
<td>Paresis of Accommodation</td>
</tr>
<tr>
<td>367.52</td>
<td>Total or Complete Internal Ophthalmoplegia</td>
</tr>
<tr>
<td>367.53</td>
<td>Spasm of Accommodation</td>
</tr>
<tr>
<td>367.81</td>
<td>Transient Refractive Change</td>
</tr>
<tr>
<td>367.89</td>
<td>Other Disorders of Refraction and Accommodation</td>
</tr>
<tr>
<td>367.9</td>
<td>Unspecified Disorder of Refraction and Accommodation</td>
</tr>
</tbody>
</table>

Examples

Established patient - 68 year old male diabetic patient presents for yearly eye exam. Diabetes under control, but he states that he has noticed a small change in his vision, especially the right eye, since last eye exam. Eye exam performed and early cataract noted. Issued prescription for glasses and advised to return in six months. Bill the appropriate eye code based on documentation (i.e. 92012).

Established patient - 67 year old female with a two-day history of acute conjunctivitis. Extensive history of possible exposures, prior normal ocular history and medication use is obtained. Comprehensive eye exam is performed and prescription written for antibiotic eye drops. Bill appropriate E&M code based on documentation (i.e. 99213).

Billing

Indian Health Services (IHS) can submit medically necessary optometry visits to Medicare.

Outpatient hospitals and their provider-based clinics will submit a Type of Bill (TOB) 131, with revenue code 0510 and the visit code, to Part A (UB-04). A separate Part B claim (CMS-1500) can be submitted for the physician’s service, using a Place of Service (POS) code 22 (with exception of Glaucoma Screening).

Freestanding clinics will submit only a Part B claim, using POS code 11.
Special Coverage

**Diabetic retinopathy services** – Services covered for diabetic patients who are at risk for retinopathy include:

- Eye exams
- Ophthalmoscopy
- Fluorescein angiography
- Fundus photography

**Glaucoma screening** – Glaucoma screenings are covered annually for patients who are in a high-risk category:

- Patients with diabetes mellitus
- Family history of glaucoma
- African-Americans aged 50 and older
- Hispanic-Americans aged 65 and older

Glaucoma screening is submitted with diagnosis V80.1 and one of the following codes:

- G0117 – Performed by an Optometrist or Ophthalmologist
- G0118 – Under the direct supervision of an Optometrist or Ophthalmologist

Outpatient hospitals and their provider-based clinics will submit a Part A claim, with TOB 131, revenue code 0510, diagnosis V80.1 and one of the above codes. No Part B claim submitted.

Freestanding clinics will submit these services on a Part B claim, using POS 11.

**Cataract Surgery** – Medicare covers cataract surgery however, Novitas-Solutions has established an LCD that includes patient documentation and testing requirements and specific diagnoses. Refer to the Novitas-Solutions medical policy for cataract surgery.

[www.novitas-solutions.com](http://www.novitas-solutions.com)

**Surgical Co-Management (Modifiers 54 and 55)**

Medicare covers surgical co-management for appropriate reasons such as inability of the operating surgeon to provide postoperative care, inability of the patient to return to see the operating surgeon in the postoperative period for a variety of reasons or patient preference. For example, one physician may perform the surgery, but another physician may provide the follow-up care.

**54 Modifier  Surgical Care Only:** One physician performs a surgical procedure and another provides preoperative and/or postoperative management.

**55 Modifier  Postoperative Management Only:** One physician performs the postoperative management and another physician performs the surgical procedure.

Example: Patient referred to outside Ophthalmologist for cataract surgery only. Patient will return to IHS provider for follow-up care.

Surgeon will submit a claim with surgical code and 54 modifier. IHS provider will submit the same procedure code used by surgeon with 55 modifier. Claim will show date of service in item 24A as
surgery date and units will be number of follow-up days provided (i.e. 90). Item 19 (or electronic equivalent) will list the actual date care was assumed by IHS provider and relinquished date (should equal total units field).

**Resources:**

Refer to the CMS NCD web site and/or the Novitas Solutions LCD web site for coverage requirements for specialty services.

CMS Ophthalmology Resource Center:


AMA CPT manual.