Supplemental Vision Benefit - Routine/Screening Eye Examinations

UCare offers a supplemental vision benefit to UCare for Seniors members that provides one routine/screening eye examination once a year. The following information is provided to ensure that members receive the supplemental benefit to which they are entitled and that claims for this service are submitted accurately.

ROUTINE/SCREENING EYE EXAMINATION

UCare defines a routine/screening eye examination as a comprehensive vision service that consists of both of the following components:

- **Comprehensive Ophthalmological Examination** - a detailed evaluation of the physiological function and the anatomical status of the eye, visual system, and its related structures;

  and

- **Refraction** - an examination that evaluates an individual's ability to see an object at a specific distance and whether an individual has normal vision. It is also used to determine the prescription for eyeglasses or contact lenses.

An eye examination of this nature is considered a “preventive” service as it is performed in the absence of an eye disease, injury or other eye-related sign or symptom.

UCare requires that both CPT codes listed below for the routine/screening vision service be performed and submitted at the same encounter and reported on a claim form as follows:

- CPT code 92014 should be used to report a routine/screening eye examination
- For purposes of this supplemental benefit, CPT code 92014 should be reported for either a new patient or an established patient
- CPT code 92015 should be used to report refraction
- Both CPT codes MUST be submitted using V72.0 (Examination of the eyes and vision) as the primary diagnosis

When present, the diagnoses of hypermetropia (367.0), myopia (367.1), astigmatism (367.20, 367.21 or 367.22) and presbyopia (367.4), considered benign refractive eye disorders, should be submitted on the claim form as secondary or subsequent diagnoses.

Use of the V72.0 code clearly indicates that the service is of a routine or screening nature, performed in the absence of an eye disease or injury. A routine/screening eye examination billed without the V72.0 as the primary diagnosis will result in the claim being returned to the provider for correct diagnosis coding.

Refraction should not be reported as a single service (not reported with any other CPT codes) on a claim, whether it is billed as a routine/screening service or performed in conjunction with an intermediate or comprehensive medical eye evaluation. If refraction is submitted as the only vision service on either a screening or medical vision claim, it will be denied.
Routine/Screening Eye Examination Criteria

All routine/screening eye examinations provided to UCare for Seniors members must include the following components (unless there is a documented contraindication for a specific element):

- Visual acuity with current correction (the power of the present correction recorded) at distance and, when appropriate, at near
- Measurement of best corrected visual acuity (with a refraction when indicated)
- Visual fields by confrontation
- External examination (e.g., eyelid position and character, lashes, lacrimal apparatus and tear function; globe position; and pertinent facial features)
- Pupillary function (e.g., size and response to light, relative afferent pupillary defect)
- Ocular alignment and motility
- Slit-lamp bio microscopic examination: eyelid margins and lashes; tear film; conjunctiva; sclera; cornea; anterior chamber; and assessment of central and peripheral anterior chamber depth, iris, lens, and anterior vitreous
- Intraocular pressure measurement, preferably with a contact applanation method (typically a Goldmann tonometer); contact tonometry may be deferred in the setting of suspected ocular infection
- Fundus examination: mid and posterior vitreous, retina (including posterior pole and periphery), vasculature, and optic nerve

MEDICAL EYE EXAMINATIONS
Intermediate and Comprehensive Ophthalmological Services

Intermediate and comprehensive ophthalmological services are typically not considered routine or screening services as they involve both the evaluation and management of a new problem, often impacting an existing condition (intermediate ophthalmological service) or a comprehensive ophthalmological service that always involves initiation of diagnostic and treatment programs. The CPT Manual provides excellent descriptions of these services.

Intermediate and comprehensive ophthalmological services are reported using the following CPT codes:

- 92002 Intermediate ophthalmological service, new patient
- 92004 Comprehensive ophthalmological service, new patient
- 92012 Intermediate ophthalmological service, established patient
- 92014 Comprehensive ophthalmological service, established patient

When these services are performed because of an acute eye condition, eye injury, exacerbation of an existing eye disorder or management of a chronic eye problem, they should be reported on a claim using the ICD-9-CM diagnosis code that represents the sign, symptom, problem or injury being evaluated and treated. Medical eye examinations should never be reported using a V72.0 (routine or screening eye examination).
To summarize:

- UCare offers a supplemental routine/screening eye care benefit to *UCare for Seniors* members once per calendar year. There is no cost to the member for this service.
- Routine/screening eye examinations for *UCare for Seniors* members must include both a comprehensive eye examination and a refraction.
- The comprehensive ophthalmological examination must include all of the components defined above (unless medically contraindicated).
- Routine/screening eye examinations must be billed with CPT code 92014.
- For purposes of the supplemental vision benefit only, CPT code 92014 must be reported for either a new patient or an established patient.
- Refraction must be billed with CPT code 92015.
- The routine/screening eye examination and the refraction must be billed with ICD-9-CM code V72.0 as the primary diagnosis.
- Eye examinations related to an acute eye condition, eye injury, exacerbation of an existing eye disorder or management of a chronic eye problem are considered medical eye examinations.
- Medical eye examinations must be billed with CPT codes 92002, 92004 (for new patients) or 92012, 92014 for established patients.
- Medical eye examinations must be billed with medical diagnoses as the primary and subsequent codes.
- Medical eye examinations should never be billed with V72.0 (routine/screening eye examination).
- Claims for medical eye examinations are processed just as any other medical claim and there is a member cost share for a medical eye examination.

Examples:

**Routine/Screening Eye Examination**

1. 92014  V72.0, 367.1
2. 92015  V72.0

**Medical Eye Examination**

2. 92002  365.22 (acute glaucoma)

**Questions?**

Thank you for your patience as we implement this new statute. If you have questions about UCare’s process, please contact our Provider Assistance Center at 612-676-3300 or 1-888-531-1493, Monday – Friday, 7 a.m. – 5 p.m.