Vision Services Professional Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

The following payment policy applies to Tufts Health Plan contracting ophthalmologists who render professional vision services in an outpatient or office setting.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary vision services, in accordance with the member's benefits.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Commercial Provider Services or Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

Services, including periodic follow-up eye exams, are considered "nonpreventive/nonroutine" for members with an eye disease such as glaucoma or a condition such as diabetes.

Routine Eye Examinations and Optometry Medical Services

Tufts Health Plan has arranged for administration of the vision benefit through EyeMed Vision Care.

Ophthalmologists

Ophthalmologists must be contracted with EyeMed Vision Care in order to provide routine eye services or dispense eyewear to Tufts Health Plan members. Ophthalmologists may provide nonroutine, medical eye services to members according to their Tufts Health Plan agreement.

POS and PPO members who choose to obtain routine/preventive or optometry medical services outside of the EyeMed Vision Care network using their unauthorized level of benefits may be responsible for an applicable cost share.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Authorization and Notification Policy.

Commercial Products

Certain services may require prior authorization. Refer to the medical necessity guidelines in the Provider Resource Center to determine which vision services require prior authorization.

- Routine eye and optometry medical services may require prior authorization through EyeMed Vision Care. For additional information about EyeMed Vision Care policies and procedures, refer to their website or call 866.339.3633.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

- Ophthalmology medical services may require prior authorization through Tufts Health Plan's Precertification Operations Department.
- Imaging services may require prior authorization through NIA. Refer to the High-Tech Imaging Prior Authorization Program for more information.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO
Referrals are not required for routine eye services. However, medical services to an ophthalmologist require a referral from the member's PCP.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

- Submit routine eye and optometry medical services to EyeMed Vision Care.
- Submit ophthalmology medical services and imaging services to Tufts Health Plan.

Intraocular Lenses
In accordance with CMS requirements, members who request the insertion of a presbyopia-correcting intraocular lens (P-C IOL) or astigmatism-correcting intraocular lenses (A-C IOLs) instead of a conventional IOL following removal of a cataract will be responsible for the additional cost of the P-C IOL or A-C IOL.

Providers should submit the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL. Providers may also submit an additional HCPCS code, V2788 (Presbyopia-Correcting IOL) or V2707 (Astigmatism-Correcting IOL), to indicate any additional charges that accrue when a P-C IOL or AC-IOL is inserted in lieu of a conventional IOL.

Note: There is no member responsibility for P-C IOLs or A-C IOLs for Tufts Health Plan SCO members.

Routine Eye Care Services
The following ICD-10 diagnoses will be processed as routine eye care services for members age 19 and over:

- Amblyopia (H53.001-H53.042)
- Esotropia (H50.00-H50.08)
- Exotropia (H50.10-H50-18)

The following procedure codes, when billed with a routine ICD-CM diagnosis code, are for routine eye services. Optometrists and ophthalmologists should bill EyeMed Vision Care for the procedure codes listed below:

Procedure Code	Description
92002	New patient, intermediate visit
92004	New patient, comprehensive visit
92012	Established patient, intermediate visit
92014	Established patient, comprehensive

The following ICD-CM diagnosis codes have been classified as **routine** by Tufts Health Plan:

Diagnosis Code	Description
H52.00	Hypermetropia, unspecified eye
H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.10	Myopia, unspecified eye
H52.11	Myopia, right eye
H52.12	Myopia, left eye

Diagnosis Code	Description
H52.13	Myopia, bilateral
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.209	Unspecified astigmatism, unspecified eye
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.219	Irregular astigmatism, unspecified eye
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.229	Regular astigmatism, unspecified eye
H52.31	Anisometropia
H52.32	Aniseikonia
H52.4	Presbyopia
H52.511	Internal ophthalmoplegia (complete) (total), right eye
H52.512	Internal ophthalmoplegia (complete) (total), left eye
H52.513	Internal ophthalmoplegia (complete) (total), bilateral
H52.519	Internal ophthalmoplegia (complete) (total), unspecified eye
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.529	Paresis of accommodation, unspecified eye
H52.531	Spasm of accommodation, right eye
H52.532	Spasm of accommodation, left eye
H52.533	Spasm of accommodation, bilateral
H52.539	Spasm of accommodation, unspecified eye
H52.6	Other disorders of refraction
H52.7	Unspecified disorder of refraction
H53.71	Glare sensitivity
H53.72	Impaired contrast sensitivity
H53.8	Other visual disturbances
H53.9	Unspecified visual disturbance
Z01.00	Encounter for examination of eyes and vision without abnormal findings
Z01.01	Encounter for examination of eyes and vision with abnormal findings

The following ICD-10 diagnoses will process as **medical** when billed with a routine diagnosis:

ICD-10 Code(s)	Diagnosis
A18.50-A18.59	Tuberculosis of eye
A74.0	Chlamydial conjunctivitis
B30.0-B30.9	Viral conjunctivitis
B39.4-B39.9	Histoplasmosis
B60.13	Keratoconjunctivitis due to Acanthamoeba
C44.101-C44.199	Other and unspecified malignant neoplasm of skin of eyelid, including canthus

ICD-10 Code(s)	Diagnosis
D22.10-D22.12	Melanocytic nevi of eyelid, including canthus
D23.10-D23.12	Other benign neoplasm of skin of eyelid, including canthus
D31.00-D31.92	Benign neoplasm of eye and adnexa
E08.00-E13.9	Diabetes mellitus
G35	Multiple sclerosis
G45.3	Amaurosis fugax
G93.0-G93.2	Other disorders of brain
H01.001-H02.9	Other inflammation of eyelid
H15.001-H43.9	Disorders of sclera
H44.121-H44.129	Parasitic endophthalmitis, unspecified
H44.50-H44.539	Degenerated conditions of globe
H44.811-H49.9	Other disorders of globe
H50.21-H51.9	Vertical strabismus
H53.10-H53.489	Subjective visual disturbances
H53.60-H53.69	Night blindness
H54.0-H57.9	Blindness
H59.40-H59.43	Inflammation (infection) of postprocedural bleb
Q10.0-Q15.9	Congenital malformations of eyelid, lacrimal apparatus and orbit
R44.1	Visual hallucinations
S00.10XA-S00.279S	Contusion of eyelid and periocular area
S05.00XA-S05.12XS	Injury of conjunctiva and corneal abrasion without foreign body
S05.8X1A-S05.92XS	Other injuries of right eye and orbit
T15.00XA-T15.92XS	Foreign body in cornea
T85.310A-T85.398S	Breakdown (mechanical) of prosthetic orbit of right eye
T86.8401-T86.8499	Corneal transplant rejection

Bilateral Procedures

Tufts Health Plan covers CPT procedure code 92235 bilaterally. 92235 cannot be billed bilaterally with two units. In order to be compensated bilaterally, providers should submit procedure code 92235 on one line with one unit appended with the appropriate modifier. For more information, refer to the Bilateral and Multiple Procedures Payment Policy.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

Optometrists rendering routine eye and medical services, and ophthalmologists rendering routine eye services are compensated according to the EyeMed Vision Care contract.

All Products

Refractions

Tufts Health Plan does not separately compensate for determination of refractive state (92015) when billed with a routine eye care diagnosis, as it is considered included in the routine eye examination.

Diabetic Members

Claims for eye exams for diabetic members are processed as part of the medical benefit.

Frequency Policies and Descriptions

Tufts Health Plan sets frequency limits on certain ophthalmology procedures based on medical necessity. The following are policies that fall within frequency limitations:

Policy	Description
Fundus photography	Tufts Health Plan provides coverage for procedure code 92250 (with interpretation and report) up to two times in a 12-month period.
Ophthalmoscopy	Tufts Health Plan provides coverage for CPT procedure code 92201 (ophthalmoscopy, extended, with retinal drawing, with interpretation and report; initial) once per year. Subsequent services should be billed using CPT procedure code 92202 (ophthalmoscopy, extended, with retinal drawing, with interpretation and report; subsequent).
Ophthalmologic services	Tufts Health Plan provides coverage for CPT procedure code 92014 (ophthalmological services; comprehensive, established patient one or more visits) once within six months. **Note:** If the patient is being seen for follow up within six months of the comprehensive ophthalmologic service for the same condition, providers should bill using CPT procedure code 92012 (ophthalmological services, medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate established, patient).
Ophthalmic ultrasound	Tufts Health Plan does not routinely compensate 76514 (ophthalmic ultrasound, diagnostic) more than once in a patient's lifetime.

Ophthalmology Edits
Tufts Health Plan does not routinely compensate for the following when billed without an appropriate diagnosis:

- Ophthalmoscopies (92201-92202)
- Scanning computerized ophthalmic diagnostic imaging ([SCODI] 92132-92134)

Ophthalmoscopy
Tufts Health Plan does not routinely compensate additional units of extended ophthalmoscopy (92201-92202) when billed more than six units per eye within 365 days with a diagnosis of disorders of the globe, choroid, retina, iris and ciliary body or glaucoma.

Ophthalmoscopy and Fluorescein Angiography
Tufts Health Plan does not routinely provide coverage for 92201-92202 when billed with 92235 (fluorescein angiography), as 92201 and 92202 are included in 92235. Tufts Health Plan will consider compensation if the appropriate modifier is submitted.

Special Ophthalmological Services
Tufts Health Plan does not routinely compensate special ophthalmological services (92020-92287, 76510-76514, 76516, 76519) if an encounter for general/routine/screening examination is the only diagnosis on the claim.

Visual Field Examinations
Tufts Health Plan does not routinely compensate visual field examinations (92081-92083) if billed without a requisite diagnosis, per the American Academy of Ophthalmology and CMS policy.

Vitrectomy
Tufts Health Plan does not routinely compensate for vitrectomy unless vitreous loss, retinal detachments secondary to vitreous strands, proliferative retinopathy, or vitreous retraction is also reported on the claim. Refer to the CMS NCD Manual for more information.

Commercial Products Only
Cataract Surgery
Tufts Health Plan does not routinely compensate for 0191T (initial insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach) unless the removal of lens/cataract is also present on the claim, as it exceeds clinical guidelines.

Corneal Tissue Processing, Preserving and Transportation
Tufts Health Plan does not routinely compensate for processing, preserving, and/or transporting corneal tissue (V2785) when billed without a corneal transplant procedure (65710, 65730, 65750, 65755, 65756, 65765, 65767).

Ophthalmic Ultrasound
Tufts Health Plan limits coverage for diagnostic ophthalmic ultrasounds (76510-76512) three times within a 12-month period.[3]

Vision Screening and Evaluation and Management Services
Tufts Health Plan does not routinely compensate for a vision screening when billed with a routine ophthalmologic exam. An E&M service for an eye-related condition is deemed to include a quantitative screening test of visual acuity. Visual screening is deemed included in the E&M service or general ophthalmologic service.

Vitrectomy
Tufts Health Plan does not routinely compensate for vitrectomy (67005, 67010, 67036, 67039-67043) if billed without a required diagnosis.

Global Procedures
CPT codes 92201 or 92202 billed with 92004, 92014, 99204, 99205, 99214, 99215, 99244, 99245, or 99250 will deny as included in the primary procedure.

OPHTHALMOLOGY IMAGING PRIVILEGING FOR NONRADIOLOGISTS (COMMERCIAL PRODUCTS)

The Tufts Health Plan Imaging Privileging Program is a utilization management tool designed to address quality and utilization issues related to nonemergency, outpatient diagnostic imaging provided by nonradiologists. The program's goal is to enhance quality and patient safety, assure the appropriateness of tests, and improve cost-effectiveness while minimizing disruption of health care delivery.

Tufts Health Plan must privilege providers who are nonradiologists and who provide imaging services within an office setting. In order to be compensated, services for which a provider is privileged are considered integral to the practice of the provider. In most instances, privileging to perform specialty appropriate procedures is granted based on a provider's specialty designation.

Tufts Health Plan does not cover MRI/MRA, CT/CTA, and PET services performed by a nonradiologist. This includes both the technical and/or professional component. MRI/MRA, CT/CTA, and PET procedures must be performed in a contracted designated freestanding imaging center or a contracted hospital.

The following list contains approved CPT procedure codes for ophthalmology. Any imaging modalities and/or CPT procedure codes not listed within this table are not covered for nonradiologists.

Diagnostic Imaging Study

CPT Code	Description
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
76511	Ophthalmic ultrasound, diagnostic, A-scan only
76512	Ophthalmic ultrasound, diagnostic, contact B-scan (with or without A scan)
76513	Ophthalmic ultrasound, diagnostic, immersion (water bath) B-scan
76514	Ophthalmic ultrasound, corneal pachymetry
76516	Ophthalmic biometry by ultrasound, A-scan
76519	Ophthalmic biometry by ultrasound, A-scan w/intraocular lens power calculation
76529	Echo exam of eye for foreign body

DOCUMENT HISTORY

- February 2021: Updated ICD-10 code range for corneal transplant rejection
- October 2020: Replaced CPT codes 92225 and 92226 with 92201 and 92202, per AMA coding guidelines
- May 2020: Added previously communicated intraocular lens information
- November 2018: Added edits for visual field examinations, effective for dates of service on or after January 1, 2019
- August 2018: Added claim edit for special ophthalmological services, effective for dates of service on or after October 1, 2018
- June 2018: Template updates

[3] Applies to Commercial products only.

- February 2018: Added claim edits for ophthalmoscopy, effective for dates of service on or after April 1, 2018
- November 2017: Added claim edits for corneal tissue processing, preserving and transporting, and vitrectomy, effective for dates of service on or after January 1, 2018; clarified H53.042 as a routine diagnosis for amblyopia
- July 2017: Reviewed by committee; added Tufts Medicare Preferred HMO and Tufts Health Plan SCO content to combine
- January 2017: Template updates
- July 2016: Added ophthalmoscopy and scanning computerized ophthalmic diagnostic imaging edits effective for dates of service on or after October 1, 2016.
- January 2016: Added policy information for 0191T, effective for dates of service on or after April 1, 2016, template updates
- September 2015: Template conversion, template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.