Clinical Policy: Special Ophthalmological Services

Reference Number: WNC.CP.257
Last Review Date: 02/2025

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given. Interpretation and report by the physician is an integral part of special ophthalmological services where indicated.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Special Ophthalmological Services have the following coverage criteria:

A. ***Computerized Corneal Topography*** is covered when it is determined to be medically necessary, the Member meets **any** of the following indications below **AND** the results will assist in defining further treatment:

1. Pre-operative evaluation of irregular astigmatism for intraocular lens power determination with cataract surgery;
2. Monocular diplopia;
3. Diagnosis of keratoconus;
4. Post-surgical or post-traumatic astigmatism, measuring at a minimum of 3.5 diopters;
5. Suspected irregular astigmatism based on retinoscopic streak or conventional keratometry;
6. Post-penetrating keratoplasty surgery;
7. Post-surgical or post-traumatic irregular astigmatism;
8. Corneal dystrophies;
9. Complications of transplanted cornea;
10. Post-traumatic corneal scarring; **OR**
11. Pterygium or corneal ectasia that cause visual impairment.

B. ***Sensorimotor Examination*** is covered when considered medically necessary for **ANY** of the following conditions:

1. Diplopia;
2. Exotropia;
3. Esotropia;
4. Hypertropia; **OR**

5. Paralytic strabismus.

C. ***Fitting of Contact Lens*** is covered for the treatment of disease for **ANY** of the following conditions:
1. Bullous keratopathy;
2. Dry eyes;
3. Corneal ulcers;
4. Corneal abrasions;
5. Keratitis;
6. Corneal edema;
7. Descemetocele;
8. Corneal ectasis;
9. Mooren's ulcer;
10. Anterior corneal dystrophy; **OR**
11. Neurotrophic keratoconjunctivitis.
12. The initial fitting of gas permeable contact lens is indicated for the management of keratoconus.

D. ***Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)*** is covered to diagnose early glaucoma and monitor glaucoma treatment in members with mild to moderate damage. Glaucomatous damage is defined by **ONE** of the following criteria:
1. Glaucoma-suspect or mild glaucomatous damage (mild stage glaucoma):
    a. Anomalous appearing optic nerve;
    b. Intraocular pressure greater than 22 mmHg as measured by applanation;
    c. Symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ratio greater than 4.0;
    d. Focal optic disk notch;
    e. Optic disk hemorrhage or history of optic disk hemorrhage;
    f. Nasal step or small paracentral or arcuate scotoma; **OR**
    g. Mild constriction of visual field isopters.
2. Moderate glaucomatous damage (moderate stage glaucoma):
    a. Enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio greater than 0.5, but less than 0.9;
    b. Definite focal notch with thinning of the neural rim; **OR**
    c. Definite glaucomatous visual field defect, e.g., arcuate or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters.
3. Advanced glaucomatous damage (severe stage glaucoma):
    a. Severe generalized constriction of isopters (i.e., Goldmann 14e greater than 10 degrees of fixation);
    b. Absolute visual field defects within 10 degrees of fixation;
    c. Severe generalized reduction of retinal sensitivity;
    d. Loss of central visual acuity, with temporal island remaining;
    e. Diffuse enlargement of optic nerve cup, with cup to disc ratio greater than 0.8; **OR**
    f. Wipe-out of all or a portion of the neural retinal rim.

E. ***Ophthalmic Biometry*** is covered when considered medically necessary and performed preoperatively for the purpose of determining intraocular lens power in a Member undergoing cataract surgery. The provider who is performing the cataract surgery shall perform the Ophthalmic Biometry.

F. ***Fundus Photography*** is covered for examination of the retina to document disease process, plan treatment or follow the progress of diabetic retinopathy in members with diabetes.

G. ***Electrophysiologic Retinal Testing*** is covered when it is determined to be medically necessary, **AND** the Member meets **ANY** of the following indications below:
1. Confirmation of neurologic or ophthalmologic disease;
2. Unexplained visual loss;
3. Family history of poor vision;
4. Inherited visual disorders; **OR**
5. Assessment of optic nerve function following trauma.

II. It is the policy of WellCare of North Carolina® that Special Ophthalmological Services are **NOT COVERED** in the following situations:

A. ***Computerized Corneal Topography*** is not covered for **any** of the following:
1. Routine follow-up testing;
2. Repeat testing if not indicated by a change of vision as reported in connection with one of the listed conditions in Subsection I.A;
3. On the same date of service as keratoplasty; **or**
4. Services performed for screening purposes.

B. ***Scanning Computerized Ophthalmic Diagnostic Imaging*** is not covered for the following:
1. To further validate a diagnosis that has been confirmed through earlier detection;
2. For members with advanced glaucomatous damage; instead, visual fields must be performed;
3. When performed in the absence of an indication as denoted by one of the diagnoses listed at State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1T-2 Special Ophthalmological Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).;
4. When performed as screening; **OR**
5. SCODI of the optic nerve and SCODI of the retina are not covered on the same date of service.

C. ***Ophthalmic biometry*** is not covered by partial coherence interferometry on the same date of service as ophthalmic biometry by ultrasound echography, A-scan.

D. ***Fundus Photography*** is not covered for **ANY** of the following:
1. To screen or evaluate retinal conditions other than diabetic retinopathy;

2. When the final composite image captured does not include the entire Diabetic Retinopathy Study seven-standard field area (DRS 7); **OR**
3. When the final retinal images are graded using an automatic process only.

Background[1]

I. Special ophthalmological services include the following procedures:

- Computerized Corneal Topography
- Sensorimotor Examination
- Fitting of Contact Lens for Treatment of Disease
- Scanning Computerized Ophthalmic Diagnostic Imaging
- Ophthalmic Biometry
- Fundus Photography
- Electrophysiologic Retinal Testing

II. Limitations:

A. Fitting of contact lens for treatment of disease is limited to *four lenses per 365 days*.

B. **Pre-glaucoma members** or those with mild damage may receive *one SCODI per 365 days.*

C. Members with moderate damage may receive up to *two SCODIs per 365 days* **OR** *one SCODI and one visual field per 365 days* if medically necessary. When both tests are performed, only one of each test is covered per 365 days.

D. Fundus photography studies are limited to *one per 365 days* for detection and interpretation of diabetic retinopathy in members with a diagnosis of diabetes mellitus.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)

CPT®* Codes	Description
92071	Fitting of contact lens for treatment of ocular surface disease
92072	Fitting of contact lens for management of keratoconus, initial fitting
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92250	Fundus photography with interpretation and report
92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report
92270	Electro-oculography with interpretation and report
92273	Electroretinography (ERG), with interpretation and report; full field (i.e., ffERG, flash ERG, Ganzfeld ERG)
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)
92283	Color vision examination, extended, e.g., anomaloscope or equivalent
92284	Dark adaptation examination with interpretation and report

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
Please see State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1T-2 Special Ophthalmological Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). for a list of applicable diagnosis codes.	

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	05/21	06/21
Reviewed CPT codes.	01/22	02/22
Annual Review. CPT codes reviewed.	11/22	11/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review. CPT codes reviewed	08/23	08/23
Annual Review. Changed Criteria II.B.3 and ICD-10-CM code box to include correct link "State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1T-2 Special Ophthalmological Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov)." Removed HCPCS code box.	02/24	02/24

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Annual Review. Removed "Medicaid and health choice" verbiage from References.	02/25	02/25

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1T-2 Special Ophthalmological Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published January 15, 2024. Accessed November 22, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.