The following coverage guidelines provide additional information regarding appropriateness of services and reimbursement policies for such services. It should be noted that reimbursement will only be issued when the diagnosis code reported on the claim supports the medical appropriateness of the services submitted.

A. Complex Cataract (CPT-4 Code: 66982)

Complex cataract is not a complication during cataract surgery. Complex cataract is something that is usually anticipated and planned for by provider based upon the member’s condition as documented in the medical record. Complex cataract surgery is defined as “Endocapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration of phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorhexis), or performed on patients in the amblyogenic development stage.” The Company will consider the following criteria in determining whether provider’s request constitutes a complex cataract:

1) Many cases with documented pseudoexfoliation of the lens capsule are considered complex

2) Any case where, when noted in the chart prior to surgery, an extremely miotic pupil is encountered and it is necessary to insert either a Malyugen ring or place iris hooks through four separate corneal paracentesis incisions will be considered complex. An operative report which clearly states the level of dilation in millimeters of the pupil under the operating microscope and the mechanical device used will be required to support the use of the code.

3) Modern coaxial fiberoptic operating microscopes have made visualization of the red reflex and therefore the performance of a capsulorrhexis possible in the vast majority of cases. Individual surgeons may choose to use trypan blue on a more routine basis but it will only be considered complex when the medical record clearly indicates that there is a hypermature (ICD-9 code 366.18) or white cataract (ICD-9 code 366.17) or a cataract with such dense brunesence that no retinal detail or red reflex can be seen. Typical pre-operative acuity will be on the order of 20/400 or worse with correction and often is light perception or finger counting.
B. **Corneal Topography (CPT-4 Code 92025 Corneal Topography)**

Corneal topography may be used for the evaluation and management of corneal diseases when clinically indicated for the following conditions: post penetrating keratoplasty, irregular astigmatism, and keratoconus. When clinically indicated, provider may render up to two corneal topography procedures in a 365 day period for the same condition without prior authorization. Additional topography requests within 365 days require prior authorization and review for medical necessity. Requests for topography with diagnoses other than the above also require prior authorization and review for medical necessity.

C. **Extended Ophthalmoscopy (CPT-4 Code 92225 & 92226)**

Routine ophthalmoscopy is covered as part of the comprehensive eye examination or the evaluation and management eye examination and is a non-itemized service. Extended Ophthalmoscopy is a detailed examination of the retina with associated documentation, going beyond an examination performed routinely by a vision provider. Extended Ophthalmoscopy-initial (CPT code 92225) and Extended Ophthalmoscopy-subsequent (CPT code 92226) are covered as separate procedures when the medical record documentation contains the symptoms and physical findings to substantiate the medical necessity and appropriateness of this procedure and appropriately detailed documentation of the location and amount of retinal pathology that is essential for the monitoring and treatment of the condition.

Such medical record documentation must include the following:

- A detailed colored drawing of the optic nerve
- Exact renderings of blood vessels out to the retinal periphery and the exact extent and location of pathology in relation to these vessels
- Documentation of cupping, disk rim and shape
- Documentation of any surrounding pathology around the optic nerve
- Documentation of the cup to disk ratio
- At least three inches in diameter

Drawing dimensions should be of an adequate size (three inches or larger) to allow ease in interpretation.
An Extended Ophthalmoscopy is not considered medically necessary to document the existence of a condition that was confirmed by another ophthalmologic test (i.e. fundus photography, fluorescein angiography or ultrasound).

An Extended Ophthalmoscopy is not medically necessary if the vision exam was sufficient to determine the patient’s treatment or retreatment plan.

Extended Ophthalmoscopy-initial will be limited to once per 3 year period per eye care practice.

D. External Ocular Photographs (CPT-4: 92285)

External ocular photographs may be clinically indicated when photo-documentation is required to track the progression or lack of progression of an eye condition, or to document the progression of a particular course of treatment. This procedure is covered only when clinically indicated. It is not covered when performed simply to document the existence of a condition in order to enhance the medical record or for general photographic documentation (e.g. to support the medical necessity for blepharoplasty). Provider must generate an interpretation and report specific to the external ocular photographs which must be included in the patient’s medical record.

E. Fundus Photography (CPT-4 code 92250)

Fundus photography may be clinically indicated when it is required to track the progression or lack of progression of an eye condition, or to document the progression of a particular course of treatment. This procedure should not be used simply to document the existence of a condition in order to enhance the medical record. This procedure is covered only when clinically indicated (the appropriate diagnosis must be present, have associated existing signs, and the procedure must be reasonable and necessary for that diagnosis). This procedure will not be covered for routine screening or at a frequency that exceeds what is reasonably necessary based upon the patient’s condition. Claims submitted for fundus photography, in the absence of associated signs, symptoms or complaints will be denied. The patient’s medical record must have medical justification for the components of this test.

Fundus photography is not considered medically necessary to document the existence of a condition that was confirmed by another ophthalmologic test (i.e. fluorescein angiography or ultrasound). Fundus photography is not medically necessary if the vision exam was sufficient to determine the patient’s treatment or retreatment plan.

Fundus photography is a bi-lateral procedure and payment is based on the reimbursement rate for a single code.
F. **Gonioscopy (CPT-4 Code 92020 Gonioscopy)**

Gonioscopy is clinically indicated for patients who are suspected of having one of the following: glaucoma, optic nerve cupping, borderline pressures, high intraocular pressures, shallow anterior chamber and/or narrow angles. Other indications include visual field defects, history of eye trauma, previous inflammations, glaucoma surgery and suspected tumor.

Medical record documentation should include the following:

- Measurement of the anatomical relationship of the "angle," whether it is open or compromised where glaucoma is concerned.
- Anatomical description of the angle where neovascularization may be a threat as in advanced diabetes and central retinal vein occlusion
- Foreign bodies in the iris and ciliary body;
- Evaluation for neoplasm of the ciliary body and iris; and
- Evaluation of angle subsequent to trauma and complications after intraocular surgery

G. **Pachymetry (CPT-4 code: 76514)**

Accepted standards of ophthalmic practice indicate that pachymetry is indicated on a once-a-lifetime basis. Pachymetry will be covered when based on an accompanying diagnosis of glaucoma (ICD9 codes 365.00 – 365.9).

Pachymetry can also be a clinical tool to monitor corneal disease such as Keratoconus (371.60 and 371.61), Corneal transplant (V42.5) and Fuchs endothelial dystrophy (371.57). The medical record must indicate the medical necessity of this procedure

H. **Lacrimal Punctum Plugs for Dry Eyes (CPT-4 Code: 68761)**

Punctum plugs are clinically indicated and covered for patients with moderately severe to severe dry eyes (i.e. Keratitis 370.00-370.55, Sicca Syndrome 710.2). The patient's medical records must support that ongoing and intense medical management (such as the treatment with topical ocular therapy) has failed. If covered by the healthplan or

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applicable regulatory guidelines, punctum plug requests for post operative dry eyes in refractive surgery patients must show documentation that intense lubrication therapy and a sixty day trial of an aqueous enhancer (i.e. Restasis like medication) have failed to relieve the patient’s ongoing symptoms.

Permanent punctum plugs and the related professional services for the insertion of the plugs are coverable provided the following criteria are met: (1) ongoing and intense medical management has failed; (2) patient complaint stating in their words their lifestyle impairment supporting a dry eye diagnosis, (3) documentation of corneal staining and irregularities and (4) there is documentation in the patient’s record demonstrating that the trial of the temporary plugs, if used, resulted in a positive effect.

The temporary collagen plugs and sterile trays used in conjunction with the insertion of either temporary or permanent plugs are not coverable. When permanent plugs are covered, reimbursement includes the cost of the permanent plug and the professional fee associated with the insertion of the plugs (temporary and/or permanent if covered by the healthplan or applicable regulatory guidelines).

I. Refraction (CPT-4 Code: 92015)

Refraction is included as part of the wellness eye examination when performed to determine visual acuity for corrective eyewear. Block Vision does not pay a separate reimbursement for the refraction when billed in conjunction with the wellness eye examination. Similarly, a diagnostic refraction (refraction used solely for medical diagnostic purposes rather than the purchase of eyewear) is included as part of the medical eye examination and Block Vision does not pay a separate reimbursement for the diagnostic refraction when billed in conjunction with the medical eye examination. For those members that have either exhausted their wellness eye exam benefit or do not have a wellness eye exam benefit, when refraction is necessary for medical diagnostic purposes it is included as part of the medical eye examination and Block Vision does not pay a separate reimbursement.

J. Screening Services

Screening services are defined as those services that are used to detect an undiagnosed disease where the patient has no signs, symptoms, laboratory evidence, radiological evidence or personal history of the disease or where a clinical exam or test is sufficient to determine the medical need for treatment (e.g. PreView PHP® or Optomap® screening services). Screening services are not coverable regardless of diagnostic findings.

As with any non-covered service, the member must be fully informed before any screening service is rendered that the screening service is a non-covered service and
the fee the member will be required to pay. The member must acknowledge his/her financial liability for the screening service in writing (e.g. an Advance Beneficiary Notice (ABN) should be obtained from a Medicare member).

K. Sensorimotor Examination (CPT-4 code 92060)

A sensorimotor examination is clinically indicated for assessing multiple measurements of ocular deviations (e.g. restrictions or paretic muscle with diplopia) with interpretation and report (separate procedure). The procedure is usually associated with tropia and associated diagnosis (e.g. CN VI palsy).

A sensor test (e.g. worth 4 dot or fly) is also required with an interpretation and report submitted for review. This procedure is only coverable for in-depth, documented workups of strabismus and suspected palsey's / paresis etc. This procedure is not coverable when a cover test or a simple prism bar measurement does not constitute a sensorimotor examination; a sensorimotor examination requires multiple measurements in all positions of gaze.

This procedure is denoted by a bilateral CPT code and is reported only once, even when the procedure is performed on both eyes. Repeated testing is coverable provided it is medically necessary based on the progression of the disease.

This procedure is covered in conjunction with an appropriate level of E&M code with separate diagnosis for the exam and procedure. It must be clearly documented in the medical records that two separate services have been rendered.

L. Serial Tonometry (CPT-4: 92100)

Indications:

1. To guide treatment during the course of acute care for symptomatic or potentially dangerous elevations of intraocular pressure, e.g., acute angle closure glaucoma.

2. When used to assess diurnal variations of intraocular pressure elevation in unstable glaucoma patients.

3. For patients with optic nerve head damage or other signs/symptoms of glaucoma.
Limitations:

1. Serial tonometry is coverable when a minimum of three readings over at least a six hour period is clinically indicated; performing tonometry more than once during an examination is not serial tonometry.

2. A written report and interpretation is required to submit for this procedure.

3. This procedure will only be paid once per day for each patient provided it is clinically indicated.

M. Visual Field & Scanning Imaging

CPT-4: 92081 limited examination, CPT-4: 92082 intermediate examination, 92083 extended examination

Visual Fields for glaucoma ICD-9 codes

CPT-4: 92132 - Scanning computerized ophthalmic diagnostic imaging for anterior segment

Imaging for an evaluation of anterior chamber is allowed with a diagnosis of anatomical narrow angles (365.02) and the medical record must support medical necessity of test.

CPT-4: 92133 - Scanning computerized ophthalmic diagnostic imaging for glaucoma

ICD-9 codes

Scanning computerized ophthalmic diagnostic imaging, visual field testing, optic nerve-head and retinal nerve fiber layer assessment, disc photos, and intraocular pressures are all used to diagnosis and manage patients with glaucoma. When visual field testing and optic nerve-head assessment are inconclusive to diagnosis glaucoma a scanning computerized ophthalmic diagnostic imaging would meet criteria to assist in diagnosing glaucoma.

It is not enough to link the specific procedure code to a correct payable ICD-9-DM code. The appropriate diagnosis or clinical signs/symptoms and medical reason for the specific level of the procedure must be present and documented in the medical record for the specific procedure to be covered. If the medical documentation does not support the level of the procedure billed, the procedure will be denied.

When clinically indicated to diagnose glaucoma, Block Vision covers two diagnostic glaucoma tests (either visual fields, computerized ophthalmic diagnostic imaging, or combination thereof) per patient per eye per 365 days. All additional scanning computerized ophthalmic diagnostic imaging or visual field testing for glaucoma testing
over this limit or for use of this test for any diagnosis other than glaucoma must be prior 
authorized by Block Vision.

Scanning computerized ophthalmic diagnostic imaging or visual fields is not medically 
necessary if the vision exam was sufficient to determine the patient’s treatment or 
retreatment plan.

Visual field testing will be defined based on CPT-4 as follows:

92081 Limited examination, unilateral or bilateral, with interpretation and report, 
(e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated 
test, such as Octopus 3 or 7 equivalent). This procedure is generally used with 
pre-op Blepharoplasty.

92082 Intermediate examination, unilateral or bilateral with interpretation and 
report, which is at least 2 isopters on Goldman perimeter or automated 
suprathreshold screening program or Humphrey suprathreshold automated 
diagnostic test or Octopus program 33. This procedure is generally used for 
cardiovascular attacks affecting the visual pathway, unexplained vision loss 
where the medical record supports a visual field and visual field defects on gross 
testing such as confrontation fields.

92083 Extended examination, unilateral or bilateral with interpretation and 
report, which is at least 3 isopters on Goldman perimeter plotted and static 
determination within the central 30° or quantitative automated threshold 
perimetry or Octopus G-1, 32 or 42 or Humphrey’s visual field analyzer full 
threshold programs 30-2, 24-2 or 30/60-2. This procedure is generally used to 
assist in the medical management of the condition of glaucoma/glaucoma 
suspect patients and optic nerve disorders.

Examples:

1) Two visual fields per year per patient (i.e. test is performed bi-laterally) or

2) Two scanning computerized ophthalmic diagnostic imaging test per eye per year. 
 Please specify which eye the procedure was performed on (i.e. RT or LT) or

3) One visual field on both eyes and one scanning computerized ophthalmic 
diagnostic imaging test per eye per year.

CPT-4: 92134 - Scanning computerized ophthalmic diagnostic imaging for retinal ICD-9 
codes
Diagnostic scanning lasers can be used for the evaluation and treatment of retinal diseases, especially certain macular abnormalities. The request for authorization for the scanning laser will be allowed if the record indicates this testing is necessary to initiate medical treatment for a retinal disorder. This procedure will not be authorized in stable retinal disease that has been previously diagnosed and/or treated. The medical record must support the use of the test.

N. Wellness/Routine Eye Exam (CPT-4 code: 92002, 92013, 92004, 92014, 99201 - 992**)

The determination of whether an eye examination is wellness/routine or medical in nature is dependent upon the purpose of the examination rather than on the ultimate diagnosis. When the member seeks an examination because of a complaint or symptoms of an eye disease or injury, the examination is considered to be medical in nature. When the member presents for an examination with no specific complaint (i.e. an annual eye examination) or a complaint which is consistent with an annual eye examination, the examination is considered to be wellness/routine in nature. Medical eye exams are only covered by the Company for members enrolled through a client program for which the Company administers such client’s medical eye care benefit.

A wellness eye examination is defined by (1) the type of verification obtained (wellness/routine eye exam eligibility verification obtained when member elects to use his/her wellness eye exam benefit), (2) the patient’s diagnosis relates to a wellness/routine eye condition (i.e. 367.1 myopia, 367.4 presbyopia), or (3) the initial purpose of the encounter was for a wellness eye exam. The encounter will be classified as wellness/routine based upon these factors and will not be covered as a medical eye exam (i.e. eye exam considered wellness/routine based upon member’s utilization of annual wellness eye exam benefit regardless of a medical diagnosis at the time of the annual exam).

O. CPT-4: 92071 or 92072 Bandage Contact Lenses

Bandage contact lenses are used in ophthalmic practices to alleviate patient symptoms and protect the cornea for a variety of corneal disorders. The majority of times the use is short term, but in some cases a long term use of the bandage contact lens might be medically necessary.

It is the Company’s policy not to reimburse for short term bandage contact lenses to treat diagnoses such as corneal abrasions. Short term is defined as any timeframe less than one week in duration.

A bandage contact lens that is used for long term (greater than one week) treatment of a corneal disorder (e.g. bullous keratopathy) is covered when the patient’s medical record
contains documentation showing the necessity for this treatment. An invoice will be required for reimbursement for the bandage contact lens that is used.

P.  **Macular Degeneration**

The treatment of macular degeneration should be based upon accepted existing scientific protocols and procedures. Treatment that is contrary to accepted existing scientific studies (i.e. PIER, ANCHOR, or MARINA studies) will not be covered.

Q.  **Vision Therapy**

Definition:

Vision Therapy is a sequence of activities individually prescribed and monitored by the optometrist or ophthalmologist to develop efficient visual skills and visual processing. Vision Therapy is administered in-office and must be conducted under the direct supervision of the doctor.

Coverage Determination Process:

Vision Therapy must be clinically indicated based upon the results of a comprehensive eye exam. Provider must submit all supporting documentation to the Company regarding the medical necessity of Vision Therapy prior to commencing the Vision Therapy treatment plan. Such documentation should include, at a minimum, the following: information regarding the member’s diagnosis/condition, including signs, symptoms, and diagnostic factors; the relevant data from the initial diagnostic visit; the expected duration of the treatment plan, and a statement of the prognosis. The coverage determination will be based upon the shorter of the following: (i) the number of hours of Vision Therapy permitted in accordance with the member’s benefit coverage; or (ii) the number of hours of Vision Therapy reasonably appropriate for the member’s condition. Additional hours of Vision Therapy beyond the expected number of hours for which the coverage determination was made requires the provider to submit to the Company a summary report that includes the following: the relevant data from the most recent progress evaluation; an estimate of the additional number of hours of Vision Therapy, the prognosis for the patient; and what additional outcome measures and behavioral measures are expected from the continued care.

Limitations:

Applicable regulatory and/or benefit plan coverage guidelines and limitations apply (e.g. number of hours of Vision Therapy may be limited by regulation and/or the terms of the member’s benefit plan).

R.  **Exceptional or Unusual Services**

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Claims for services that are furnished beyond the accepted standards of ophthalmic practice should be submitted with documentation to justify the medical need for these services and will be considered on an individual basis.