Vision Services Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

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

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

Policy

CarePartners of Connecticut 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 CarePartners of Connecticut Provider Services at 888-341-1508.

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

Routine Eye Examinations and Optometry Medical Services

CarePartners of Connecticut 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 CarePartners of Connecticut members. Ophthalmologists may provide non-routine, medical eye services to members according to their CarePartners of Connecticut agreement.

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, Prior Authorization and Notification Policy.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut 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.

- Submit routine eye and optometry medical services to EyeMed Vision Care
- Submit ophthalmology medical services and imaging services to CarePartners of Connecticut

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 standard IOL.

Routine Eye Care Services

The following ICD-CM diagnoses will be processed as routine eye care services:

- 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 CarePartners of Connecticut:

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
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

Diagnosis Code	Description
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	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
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
T86.840-T86.849	Corneal transplant rejection

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

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

Diabetic Members

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

Frequency Policies and Descriptions

CarePartners of Connecticut sets frequency limits on certain ophthalmology procedures based on medical necessity. The following are policies that fall within frequency limitations:

Fundus Photography

Tufts Health Plan provides coverage for procedure code 92250 (with interpretation and report) up to two times in a 12-month period.

Ophthalmic Ultrasound

76514 (ophthalmic ultrasound, diagnostic) may be compensated once in a patient's lifetime.

Ophthalmologic Services

CarePartners of Connecticut does not routinely compensate for the following when billed without an appropriate diagnosis:

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

92014 (ophthalmological services; comprehensive, established patient one or more visits) is covered once within a six-month period.

Note: use 92012 for follow-up services within six months of the comprehensive ophthalmologic service for the same condition.

Ophthalmoscopy

CarePartners of Connecticut will 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.

CarePartners of Connecticut provides coverage for CPT procedure code 92201 (ophthalmoscopy, extended, with retinal drawing, interpretation and report; initial) once per calendar/benefit year. Subsequent services should be billed using CPT procedure code 92202 (ophthalmoscopy, extended, with retinal drawing, with interpretation and report; subsequent).

Ophthalmoscopy and Fluorescein Angiography

CarePartners of Connecticut does not routinely provide coverage for 92201-92202 when billed with 92235 (fluorescein angiography [includes multiframe imaging] with interpretation and report), as 92201 and 92202 are included in 92235. CarePartners of Connecticut will consider compensation if the appropriate modifier is submitted.

Refractions

92015 (determination of refractive state) is not separately compensated, in accordance with CMS.

Special Ophthalmological Services

CarePartners of Connecticut will 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.

Document History

- November 2024: Annual policy review; administrative updates
- November 2023: Annual policy review; administrative updates
- February 2023: Annual code updates
- November 2022: Annual policy review
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- October 2020: Replaced CPT codes 92225 and 92226 with 92201 and 92202, per AMA coding guidelines
- May 2020: Added previously communicated information for intraocular lenses
- January 2020: Eliminate referral requirements for in-network providers effective January 1, 2020
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut 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, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut 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 CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.