

The following payment policy applies to Tufts Health Plan[®] commercial contracted ophthalmologists who render professional vision services in an outpatient or office setting.

This policy applies to commercial¹ products. For information on Tufts Medicare Preferred HMO's policies and procedures, [click here](#).

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

Policy

Tufts Health Plan covers medically necessary vision services, as described below.

General Benefit Information²

Services and subsequent payment are based on the member's benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Refer to the [Electronic Services](#) section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [website](#) or by contacting [Provider Services](#).

Routine Eye Examinations and Optometry Medical Services

EyeMed Vision Care will arrange for routine eye and optometry medical services for Tufts Health Plan members through EyeMed's network of providers.

Optometrists

Providers must be contracted with EyeMed Vision Care in order to provide routine and medical eye services to Tufts Health Plan members.

Ophthalmologists

Providers must be contracted with EyeMed Vision Care in order to provide routine eye services to Tufts Health Plan members. Ophthalmologists may provide non-routine, medical eye services to members according to their Tufts Health Plan agreement. **Note:** With respect to members with an eye disease such as glaucoma or a condition such as diabetes, services, including periodic follow-up eye exams, are considered "non-preventive/non-routine."

Point of Service (POS) or Preferred Provider Organization (PPO) members can choose to obtain routine/preventive or optometry medical services outside of the EyeMed Vision Care network using their unauthorized level of benefits and may be responsible for an applicable coinsurance and/or deductible.

For more information about EyeMed Vision Care, visit [its website](#) or call 866-339-3633.

Member Responsibility

Copayments, deductible and/or coinsurance may apply pursuant to the member's benefit plan document.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined.

Both the provider's Statement of Account (SOA) and the Electronic Remittance Advice (ERA) will reflect the member's responsibility amount.

¹ Commercial products include [HMO, POS, PPO & CareLinkSM](#) when Tufts Health Plan is Primary Administrator.

² Eligibility is subject to retroactive reporting of disenrollment.

Authorization Requirements

Refer to the [Authorization Policy](#) for specific referral and authorization requirements. Referrals are not required for routine eye services. However, medical services require a referral from the member's PCP. Referrals are not required for certain plans, e.g., PPO.

Services Requiring Prior Authorization

Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the [Clinical Resources](#) section of our website for a list of procedures, services and items that require prior authorization. Reference the [CareLinkSM Prior Authorization List](#) for a list of procedures, services and items requiring prior authorization for CareLink members.

For a complete description of Tufts Health Plan's commercial authorization requirements, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#).

Billing Information

- Submit the most updated industry-standard codes.
- Submit standard CPT and HCPCS modifiers in accordance with the appropriate CPT or HCPCS procedure code(s).
- For more information regarding modifiers refer to the [Modifier Payment Policy](#).
- Submit routine eye and optometry medical services to EyeMed Vision Care.
- Submit ophthalmology medical services to Tufts Health Plan.

Note: Annually and quarterly, HIPAA medical code sets³ undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

EDI Claim Submitter Information

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

Paper Claim Submitter Information

- Submit claims on a CMS-1500 form for professional services. Claim line(s) billed with non-standard codes will deny.

The following procedure codes, when billed with a routine ICD-9 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

³ HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

The following diagnosis codes have been classified as routine per the ICD-9 Manual:

ICD-9 Diagnosis Code	Description
V72.0	Examination of eyes and vision
367	Disorders of refraction and accommodation
367.0	Hypermetropia
367.1	Myopia
367.2	Astigmatism
367.20	Astigmatism, unspecified
367.21	Regular astigmatism
367.22	Irregular astigmatism
367.3	Anisometropia and Aniseikonia
367.31	Anisometropia
367.32	Aniseikonia
367.4	Presbyopia
367.5	Disorders of accommodation
367.51	Paresis of accommodation
367.52	Total or complete internal ophthalmoplegia
367.53	Spasm of accommodation
367.8	Other disorders of refraction and accommodation
367.81	Transient refractive change
367.89	Other
367.9	Unspecified disorder of refraction and accommodation
368	Visual disturbance
368.8	Other specified visual disturbances
368.9	Unspecified visual disturbances

Diabetic Members

Eye exams for diabetic members are part of the medical benefit. Submit diabetic eye exams to Tufts Health Plan with the diabetes diagnosis code as the primary diagnosis.

Compensation/Reimbursement Information

Ophthalmologists are compensated according to the Tufts Health Plan network contracted rates regardless of where the service is rendered for medical vision services. Claims are subject to payment edits that are updated at regular intervals and generally based on Centers for Medicare & Medicaid Services (CMS), specialty society guidelines, drug manufacturers' package label inserts and National Correct Coding Initiative (CCI).

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

Facility Fee Reduction

Physicians who perform office visits in a hospital or outpatient clinic may be subject to a facility fee reduction. This reduction is consistent with Medicare's site of service differentiation built into Medicare fees, and parallels the facility fee reduction Tufts Health Plan applies to medical office visits in these settings. Refer to your current contract for details regarding outpatient compensation provisions.

Note: Effective January 1, 2010, Tufts Health Plan will adopt CMS's differential compensation for office and facility-based services, replacing Tufts Health Plan's standard facility fee reduction. Refer to your contract for details regarding outpatient compensation provisions.

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 will cover procedure code 92250 (with interpretation and report) up to two (2) times in a 12-month period.
Ophthalmoscopy	Tufts Health Plan will cover CPT procedure code 92225 (Ophthalmoscopy, extended, with retinal drawing, with interpretation and report; initial) once per year. Subsequent services should be billed using CPT procedure code 92226 (Ophthalmoscopy, extended, with retinal drawing, with interpretation and report; subsequent).
Ophthalmologic Services	Tufts Health Plan will cover CPT procedure code 92014 (Ophthalmological services; comprehensive, established patient one or more visits) once within 6 months. If the patient is being seen for follow up within 6 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	<p>Tufts Health Plan will cover CPT procedure code 76510 (Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter), 76511 (Ophthalmic ultrasound, echography, diagnostic; A-scan only, with amplitude quantification), 76512 (Ophthalmic ultrasound, echography, diagnostic; contact B-scan (with or without simultaneous A-scan)) three (3) times within a 12-month period.</p> <p>Tufts Health Plan will not cover 76514 (Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral [determination of corneal thickness]) more than once in a patient's lifetime.</p>

Ophthalmoscopy and Fluorescein Angiography

Tufts Health Plan will not cover 92225 (Ophthalmoscopy, extended, with retinal drawing, with interpretation and report; initial) or 92226 (Ophthalmoscopy, extended, with retinal drawing, with interpretation and report; subsequent) when billed with 92235 (Fluorescein angiography [includes multiframe imaging] with interpretation and report) as 92225 and 92226 are included in 92235. Tufts Health Plan will consider compensation if the appropriate [modifier](#) is submitted.

Vision Screening and Evaluation and Management Services

Tufts Health Plan will not compensate for a vision screening when billed with a routine ophthalmologic exam. An E&M service for an eye-related condition would regularly include a quantitative screening test of visual acuity. Visual screening is included in the E&M service or general ophthalmologic service.

Bilateral Procedures

Tufts Health Plan will cover CPT procedure code 92235 (Fluorescein angiography includes multiframe imaging with interpretation and report) bilaterally. If applicable, providers should submit procedure code 92235 on one line with one unit appended with the appropriate [modifier](#) in order to be compensated bilaterally for this code. **Effective January 1, 2011**, this code may not longer be billed bilaterally with two units.

Global Procedures

If 92225(Ophthalmoscopy, extended, with retinal drawing, with interpretation and report; initial) or 92226(Ophthalmoscopy, extended, with retinal drawing, with interpretation and report; subsequent) are billed with any of the following CPT procedure code(s) and the diagnosis code (s) is not one listed within [Attachment A](#), it will deny as included in the primary procedure:

Procedure Code	Description
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
99204 – 99205	Office or other outpatient visit for the evaluation and management of a new patient
99214 – 99215	Office or other outpatient visit for the evaluation and management of an established patient; moderate to high complexity
99244 – 99245	Office consultation for a new or established patient; moderate to high severity; 60-80 minutes
92250	Fundus Photography

Note: The diagnosis exclusion does not apply to CPT procedure code 92250.

Imaging Privileging for Non-Radiologists — Ophthalmology

The Tufts Health Plan Imaging Privileging Program is a utilization management tool designed to address quality and utilization issues related to non-emergency, outpatient diagnostic imaging provided by non-radiologists. 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 non-radiologists 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. For 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 non-radiologist. This includes both the technical and/or professional component. MRI/MRA, CT/CTA, and PET services 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 is not covered for non-radiologists.

Diagnostic Imaging Study

Procedure 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

Statement of Account (SOA)

The SOA is sent to all providers to provide information on the status of the claim(s) submitted to Tufts Health Plan. The SOA indicates status of claims payments, denials and pending claims.

If the procedure code(s) submitted is not used in processing, the SOA will reflect the actual procedure code(s) utilized by Tufts Health Plan to process the claim.

Effective January 1, 2012, paper Statements of Account and the Summary of Account on Tufts Health Plan's secure Provider website will no longer display embedded procedure code modifiers or any Tufts Health Plan unique characters.

Electronic Remittance Advice (ERA)

The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

When an industry-standard code(s) is submitted and accepted by Tufts Health Plan, the electronic remittance advice will reflect the code(s) submitted and the actual procedure code(s) utilized by Tufts Health Plan for claims processing.

Document History

December 2007: Added EyeMed Vision Care contractual requirement information.

January 2008: Added information about submitting paper referrals to optometrists.

April 2008: Clarified that the routine procedure codes when billed with a routine ICD-9 diagnosis code, are for routine eye services.

January 2009: Removed information about submitting paper referrals to optometrists

July 2010: Added facility fee reduction information.

September 2010: Added list of routine diagnosis codes.

October 2010: Clarified bilateral reimbursement of CPT code 92235

October 2011: Template updates, no content changes

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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO or Private Health Care Systems (PHCS) network also known as Multiplan members. This policy applies to CareLink when CIGNA HealthCare is Primary Administrator for providers in Massachusetts and Rhode Island service areas for pricing purposes only. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink members.