Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Refractive Vision Services

Policy Number: RM038
Last Review: 10/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
_ Facility

DESCRIPTION:

Refractive errors occurring in approximately 50% of the United States population, are disorders of the eye whereby objects either distant, close, or both, appear blurred. Refractive errors are temporarily corrected by wearing eyeglasses or contact lenses; however, once the glasses or contacts are removed, blurred vision returns.

Refraction is defined as determination of the nature and degree of the refractive errors of the eye and correction of the same by lenses. This may be done with or without eye drops in the eye. Refraction is performed by interposing lenses of distinct kinds in front of the eye until visual acuity is maximized. This examination provides the degree to which the eye differs from normal, which determines whether the individual needs corrective lenses and, if so, how strong they should be. Refraction is commonly performed for purposes of prescribing corrective lenses.

Presbyopia is an age-related visual change, which begins between 40 and 50 years of age, and results in difficulty with visual accommodation, and thus objects that are nearby are blurred. In astigmatism, the refractive power of the eye is in different meridians. As a result, objects appear blurry at any distance. This can occur with myopia (nearsightedness) or hyperopia (farsightedness). Determination of the refractive state is necessary for

obtaining glasses and includes specification of lens type (monofocal, bifocal, other), lens power, axis, prism, absorptive factor, impact resistance and other factors.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans
Effective 01/01/2024
Refraction: CPT 92015 describes refraction and any necessary prescription of lenses. Refraction is not separately reimbursed as part of a routine eye exam or as part of a medical examination and evaluation with or without treatment/diagnostic program, as it is considered included.

COVERAGE CRITERIA:
Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Effective 01/01/2024 Paramount will align with CMS indicating that refractions, 92015, are not separately payable, for all product lines.
In accordance with the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) has indicated that procedure 92015 has a payment status indicator of "N" – a non-covered service.

Refractions (CPT 92015) are considered part of the office visit and are not separately reimbursed.

Determination of refractive state is non-covered when performed for the following conditions, not an all-inclusive listing:

- **Routine eye examination; or**
- **Hypermetropia; or**
- **Myopia; or**
- **Astigmatism; or**
- **Anisometropia and aniseikonia; or**
- **Presbyopia; or**
- **Transient refractive change; or**
- **Unspecified disorder of refraction and accommodation; or**
- **Aphakia.**

Refraction performed following ocular surgery is considered to be part of the doctor's normal postoperative care. Therefore, payment for the surgical procedure includes payment for refraction performed during the postoperative period for a definitive surgical procedure.

CODING/BILLING INFORMATION:
The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
92015	Determination of refractive state

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 04/14/2015

Date	Explanation & Changes
04/14/2015	• Policy created to reflect most current clinical evidence per Medical Policy Steering Committee
05/10/2016	• Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
07/12/2016	• Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee

12/21/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/22/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
09/01/2023	• Medical Policy reviewed and updated to reflect the most current clinical evidence
12/01/2023	• Effective 01/01/2024 Paramount will align with CMS indicating that refractions, 92015, are not separately payable, for all product lines
03/08/2024	• Medical policy placed on the new Paramount Medical Policy Format
10/01/2024	• Medical policy reviewed and updated to reflect the most current clinical evidence • Medical Policy PG0331 Refractive Vision Services converted to a Reimbursement Policy RM038 Refractive Vision Services

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review