# Clinical Policy: Preventive (Routine) Eye Examination

Reference Number: CP.VP.13
Last Review Date: 08/2025

Coding Implications
Revision Log

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

## Description

A thorough ophthalmic evaluation can detect common abnormalities of the visual system and related structures as well as less common yet extremely serious ones, such as ocular tumors. Such an evaluation can also uncover evidence of systemic disease that have associated ophthalmic manifestations. All patients, particularly those with risk factors for ocular disease, should be re-examined periodically to prevent or minimize vision loss by detecting and treating the disease at an early stage.

## Policy/Criteria

**I.** It is the policy of health plans affiliated with Centene Corporation® (Centene) and Envolve Vision, Inc.® (Envolve) that preventive (routine) eye examinations are **medically necessary** for the following indications:

A. Evaluation of the visual system and related structures

1. When the initial comprehensive evaluation is normal or involves only optical abnormalities that require corrective lenses, the eye care provider reviews the findings with the patient and renders advice regarding an appropriate interval for re-examination. Although this is considered a low-risk category, periodic re-examination is indicated to detect new, potentially asymptomatic, or unrecognized ocular disease, such as glaucoma, diabetic retinopathy, and AMD, the incidence of which increases with age.
    a. Comprehensive evaluation of patients with no risk factors is recommended at the following frequencies:
        i. Pediatrics: *see CPG.VP.47 Pediatric Eye Examinations*
        ii. Adults under 40 years of age: every 5-10 years
        iii. Ages 40-54 years of age: every 2-4 years
        iv. Ages 55-64: every 1-3 years
        v. Ages 65 and older: every 1-2 years
    b. Interim evaluations, such as screenings, refractions, or less extensive evaluations, are indicated to address episodic minor problems and complaints, or for patient reassurance. The extent of the interim evaluation to be performed is determined by the patient's condition, symptoms, and by the ophthalmologist's medical judgment.
    c. A patient is considered to be at increased risk when the evaluation reveals signs that are suggestive of a potentially abnormal condition or when risk factors for developing ocular disease are identified but the patient does not yet require intervention. These situations may merit closer follow-up to monitor the patient's ocular health and to detect early signs of disease with additional testing. The eye care provider will determine the appropriate

follow-up interval for each patient based on the presence of early symptoms and signs, risk factors, the onset of ocular disease, and the potential rate of progression of a given disease.

**Background**

An eye examination consists of an evaluation of the physiological function and the anatomical status of the eye, visual system, and its related structures. This usually includes the following elements, based on the patient's history and findings, additional tests or evaluations might be indicated to evaluate further a particular structure or function:

- Visual acuity with current correction (the power of the present correction recorded) at distance and, when appropriate, at near, with a refraction when indicated;
- Visual fields by confrontation or automated screening devices (non-threshold);
- External examination (e.g., eyelid position and character, lashes, lacrimal apparatus and tear function; globe position; and pertinent facial features);
- Pupillary function (e.g., size and response to light, relative afferent pupillary defect);
- Ocular alignment and motility (e.g., cover/uncover test, alternate cover test, version and duction assessment);
- Slit-lamp biomicroscopic examination: eyelid margins and lashes; tear film; conjunctiva; sclera; cornea; anterior chamber; and assessment of central and peripheral anterior chamber depth, iris, lens, and anterior vitreous;
- Intraocular pressure measurement, preferably with a contact applanation method (typically a Goldmann tonometer). Contact tonometry may be deferred in the setting of suspected ocular infection or corneal trauma.
- Fundus examination: mid and posterior vitreous, retina (including posterior pole and periphery), vasculature, and optic nerve
    - *See clinical policy CPG.VP.24 Dilation during Examination of the Eye*
- Assessment of relevant aspects of patient's mental and physical status

Centene and Envolve have established minimum standards for practitioner documentation and maintenance of medical records including record content, record organization and maintaining confidentiality for all Protected Health Information (PHI). Providers must keep accurate and complete records that are legible, complete, dated, timed, signed and authenticated in written or electronic form by the person responsible for providing the service, including but not limited to examination notes, imaging and diagnostic tests, prescriptions, referrals, and operative notes.

All examinations require the signature of the rendering provider with the following requirements:

- The signature must be a legible handwritten signature or initials; a reviewer must be able to determine whose signature is used
- Electronic signatures should contain date and timestamps and include printed statements, e.g., "electronically signed by" or "verified/reviewed by" the rendering provider's name and preferably a professional designation. The authorship related to the signature must be clearly defined in the record.
- Digitized signature – an electronic image of the rendering provider's handwritten signature reproduced in its identical form using a pen tablet.
- Stamp signatures are not acceptable.

**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 |
|---|---|
| 92002 | Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient |
| 92004 | Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits |
| 92012 | Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient |
| 92014 | Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits |
| 92015 | Refraction |

According to the ICD-10-CM Official Guidelines for Coding and Reporting, diagnosis codes are to be used and reported at their highest number of characters available. ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail. A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the seventh character if applicable. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g. a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

Centene and Envolve comply with the coding guidelines of the health plan and/or State in which the client resides. When billing 92004/92014, the need for a comprehensive examination must be documented in the record. Abnormal comparative utilization of comprehensive examination

coding is subject to retrospective review. Refractive diagnoses unaccompanied by complicating comorbidities will be interpreted as a routine intermediate ophthalmological examination (S0620/S0621 or 92002/92012 and 92015 – if applicable).

| HCPCS Codes | Description |
|---|---|
| S0620 | Routine ophthalmological examination including refraction; new patient |
| S0621 | Routine ophthalmological examination including refraction; established patient |

The coverage of services rendered is dependent on the purpose of the examination (as reflected in the chief complaint) rather than on the ultimate diagnosis of the patient's condition. Primary ICD-10® diagnosis must match the chief complaint. Medical diagnosis codes determined at the time of routine examination should be considered a co-morbidity.

ICD-10® codes labeled "other specified" (e.g. other specified visual disturbances) or "unspecified" (e.g. subjective visual disturbance, unspecified) do not meet the requirements of a valid co-morbidity, or medical reimbursement. ICD-10® codes that describe signs and symptoms (e.g. headache, pain in or around the eye, visual discomfort), as opposed to diagnoses, are suitable only when a diagnosis has not been established and do not meet the requirements of a valid co-morbidity or medical reimbursement.

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**
+ Indicates a code requiring an additional character

| ICD-10-CM Code | Description |
|---|---|
| H52.01 | Hypermetropia, right eye |
| H52.02 | Hypermetropia, left eye |
| H52.03 | Hypermetropia, bilateral |
| H52.11 | Myopia, right eye |
| H52.12 | Myopia, left eye |
| H52.13 | Myopia, bilateral |
| H52.211 | Irregular astigmatism, right eye |
| H52.212 | Irregular astigmatism, left eye |
| H52.213 | Irregular astigmatism, right eye |
| H52.221 | Regular astigmatism, right eye |
| H52.222 | Regular astigmatism, left eye |
| H52.223 | Regular astigmatism, bilateral |
| H52.31 | Anisometropia |
| H52.32 | Aniseikonia |
| H52.4 | Presbyopia |
| H52.521 | Paresis of accommodation, right eye |
| H52.522 | Paresis of accommodation, left eye |
| H52.523 | Paresis of accommodation, bilateral |
| H52.531 | Spasm of accommodation, right eye |
| H52.532 | Spasm of accommodation, left eye |
| H52.533 | Spasm of accommodation, bilateral |

| ICD-10-CM Code | Description |
|---|---|
| Z01.00 | Encounter for examination of eyes and vision without abnormal findings |
| Z01.01 | Encounter for examination of eyes and vision with abnormal findings |
| Z01.020 | Encounter for examination of eyes and vision following failed vision screening without abnormal findings |
| Z01.021 | Encounter for examination of eyes and vision following failed vision screening with abnormal findings |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Annual Review | 12/2019 | 12/2019 |
| Converted to a new template; Revised ICD-10 diagnosis codes | 12/2020 | 12/2020 |
| Clarified recommendation for frequency of comprehensive examinations | 06/2021 | 07/2021 |
| Annual Review; Updated ICD-10 diagnosis codes related to headache; Updated References. | 12/2021 | 12/2021 |
| Added ICD-10 codes for refractive hardware to policy Attachment A. Updated references. | 08/2022 | 10/2022 |
| Annual Review | 11/2022 | 11/2022 |
| Removed diagnoses related to headaches as medical indications for routine (preventive) examination; Updated References. | 06/2023 | 07/2023 |
| Annual Review | 11/2023 | 12/2023 |
| Updated HCPCS codes for hydrophilic lenses in Attachment A | 11/2024 | 12/2024 |
| Annual Review | 08/2025 | 10/2025 |

**References**

1. ICD-10-CM Official Guidelines for Coding and Reporting 2024 Section B "General Coding Guidelines"
2. CPT® Evaluation and Management (E/M) Code and Guideline Changes, January 1, 2023, American Medical Association. 2022. Last Accessed: July 2023, https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
3. American Academy of Ophthalmology (AAO) Preferred Practice Patterns Committee. Preferred Practice Pattern®-Guidelines. Comprehensive Adult Medical Eye Evaluation. San Francisco, CA: American Academy of Ophthalmology, 2020. Available at https://www.aao.org/preferred-practice-pattern/comprehensive-adult-medical-eye-evaluation-ppp
4. American Optometric Association (AOA), Clinical Practice Guideline Comprehensive Adult Eye and Vision Examination, 2nd Edition, January 20, 2023, American Optometric Association. https://aoa.uberflip.com/i/1492068-ebo-adult-guildline-22/0?
5. Centers for Medicare and Medicaid Services (CMS), Payment Integrity Manual 100-08, https://www.cms.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. This clinical policy is not intended to recommend treatment for members. Members 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 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 and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, 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.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at https://www.cms.gov for additional information.