Provider/External Stakeholders Questions
Revisions to the (Special Ophthalmological Services 1T-2) Policy

1. What is important to your constituents/colleagues regarding this policy?

Two important elements for Special Ophthalmological Services include covering vision photoscreening for young children (through age 5 plus older when other optotypes aren’t yet reliable) and opening newly available codes 92201 and 92202.

Cover instrument-based vision screening/photoscreening

In 2016, the AAP revised its clinical guidelines to include more instrument based screening for very young children. Since then, Medicaid in South Carolina and Rhode Island have both started covering the service. Specifically, AAP recommends

- Instrument based screening, if available, can be used at any age and can be attempted beginning at age 12 months, and a previous study has demonstrated better eventual outcomes for children undergoing their first photoscreening before 2 years of age. Instrument based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate optotypes.
- Instrument-based screening can be repeated at each annual preventive medicine encounter through 5 years of age or until visual acuity can be assessed reliably using optotypes. Using these techniques in children younger than 6 years can enhance detection of conditions that may lead to amblyopia and/or strabismus compared with traditional methods of assessment.
- Instrument-based screening may be a helpful alternative in screening developmentally delayed children of any age

New CPT codes began for extended ophthalmoscopy as of 1/1/2020.

92201 Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral, and

92202 with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral.

Extended ophthalmoscopy is used in NC for premature infants both in the NICU and as outpatient until retina fully developed. It is also performed with other DM patients when detect diabetic retinopathy.
2. **Would you recommend any unit or other limitations to the service?**
   Please make sure any provision for Photo screening is not in lieu of their annual routine benefit (annual benefit is addressed in 1T-1)

3. **If this service should be limited to certain diagnoses, please include your recommendations with evidence to support the diagnoses that you have recommended.**

4. **Is there any additional evidence in medical literature on the procedure that you would like to present?**

   **AAP Letter to Medical Directors from which recommendations under # 1 are offered:**

   **Visual System Assessment in Infants, Children, and Young Adults by Pediatricians, published in Pediatrics January 2016**
   [https://pediatrics.aappublications.org/content/137/1/e20153596](https://pediatrics.aappublications.org/content/137/1/e20153596)

   **Bright Futures update adding instrument screening for vision for young children:**
   [https://www.aappublications.org/news/2016/01/04/Periodicity010416?utm_source=TrendMD&utm_medium=TrendMD&utm_campaign=AAPNews_TrendMD_0](https://www.aappublications.org/news/2016/01/04/Periodicity010416)

5. **What additional criteria would you include in the policy to define the service and identify community standards of practice?**

   **Fundus Photography:** while there is risk that this code can be abused, there are other diagnoses that would warrant medical necessity of photos: D49.81 Neoplasm of unspecified behavior of the retina and choroid, C69 family of codes (malignant neoplasms in eye: retina, choroid, ciliary, overlapping sites). Monofixation syndrome and phorias should also be listed as covered conditions.

   **Extended ophthalmoscopy** in ROP examinations: The new code 92201 is defined as, “Ophthalmoscopy, extended, with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral. These services, which are significantly more involved and technically difficult than a fundus evaluation as part of an eye examination.

   **Examination Under Anesthesia** for severely autistic children: Currently, Medicaid pays neither the ophthalmologist nor the surgery center for these examination, which is only performed if an adequate examination cannot be carried out in the office due to non-cooperative and combative behavior. For this limited population, Medicaid should consider opening code 92018 (Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, unilateral).

   **More clarity around definition and coding needed for keratoconus correction:** While the “definition” implies coverage for keratoconus correction, at least one practice has never been successful in achieving reimbursement for these costly lenses. We recommend clearer instructions (including any need for prior authorization) on how to get supply covered for these patients, and any monetary limits on what will be covered.