Clinical Policy: Preventive (Routine) Eye Examination

Reference Number: CP.VP.13
Last Review Date: 03/2026

Coding Implications
Revision Log

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

Description

Periodic ophthalmic evaluation can identify common and serious conditions affecting the visual system and may reveal signs of systemic disease with eye involvement. Periodic reexamination helps detect disease early and reduce the risk of vision loss, particularly for patients with risk factors.

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 for patients with no risk factors are recommended at the following frequencies:

A. Pediatrics: see CPG.VP.47 Pediatric Eye Examinations
B. Adults under 40 years of age: every 5-10 years
C. Ages 40-54 years of age: every 2-4 years
D. Ages 55-64: every 1-3 years
E. Ages 65 and older: every 1-2 years

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 optometrist or ophthalmologist's medical judgment.

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;
- 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 (Goldmann) method except in the presence of contraindicating 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)*; and
- Assessment of relevant aspects of patient's mental and physical status.

Centene and Envolve have established minimum standards for practitioner documentation and the maintenance of medical records, including requirements for record content, organization, and the protection of all Protected Health Information (PHI). Providers must maintain accurate and complete medical records that are legible, appropriately organized, dated, timed, signed, and authenticated, either in written or electronic form, by the individual responsible for providing the service. Documentation includes, but is not limited to, examination notes, imaging and diagnostic test results, prescriptions, referrals, and operative notes.

All examinations must include the signature of the rendering provider, in accordance with the following requirements:

- The signature must be a legible handwritten signature or initials that clearly identify the individual who signed the record.
- Electronic signatures must include the date and time stamp and a printed attestation (e.g., "electronically signed by" or "verified/reviewed by"), along with the rendering provider's name and, preferably, professional designation. Authorship associated with the signature must be clearly defined in the medical record.
- A digitized signature is acceptable when it represents an electronic image of the rendering provider's handwritten signature reproduced in its identical form (e.g., via 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 2026, 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.

Preventive (routine) eye examinations may be reported using either routine ophthalmological examination codes (S0620, S0621) or ophthalmological service codes (92002, 92012, 92004, 92014), depending on the clinical intent, documented chief complaint, market coding limitations or guidance and whether initiation or continuation of a diagnostic and treatment program is required.

Intermediate and comprehensive ophthalmological services (92002, 92012, 92004, 92014) constitute integrated services in which medical decision making cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry, or motor evaluation is not applicable.

Comprehensive ophthalmological services (92004, 92014) describe a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs. Therefore, ophthalmological services reported solely with refractive or routine diagnoses (i.e. unaccompanied by complicating comorbidities that involve the initiation of diagnostic and treatment programs) should be reported as routine intermediate ophthalmological examinations (92002, 92012).

Initiation of diagnostic and treatment program includes the prescription of medication[1], and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.

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

[1] Prescription of lenses, when required, is included in 92015. It includes specification of lens type (monofocal, bifocal, other), lens power, axis, prism, absorptive factor, impact resistance, and other factors.

condition. Primary ICD-10® diagnosis must match the chief complaint. Medical diagnosis codes determined at the time of routine examination should be considered a comorbidity.

CPT/HCPCS® 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
S0620	Routine ophthalmological examination including refraction; new patient
S0621	Routine ophthalmological examination including refraction; established patient

Per the ICD-10-CM Official Guidelines for Coding and Reporting, diagnosis codes must be reported to the highest level of specificity available. A code is considered invalid if it does not include all required characters, including a seventh character when applicable. ICD-10-CM codes labeled as "other specified" or "unspecified," as well as codes that describe signs and symptoms rather than definitive diagnoses, do not qualify as comorbidities.

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, bilateral
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
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
Updated language clarifying intermediate and comprehensive level coding per AMA's CPT Manual	03/2026	04/2026

References

1. AAPC ICD-10-CM Expert
2. American Medical Association CPT Professional Edition
3. 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
4. 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

5. 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
6. 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.