I. Policy: Ocular Photoscreening

II. Purpose/Objective:
To provide a policy of coverage regarding Ocular Photoscreening

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and

e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:** Ocular photoscreening is used to detect risk factors for amblyopia. Ocular photoscreening uses the refractive state of the eye and assesses the pattern of light reflected through the pupil. The images are then analyzed based on the position of the corneal light reflex as well as the overall reflection of light from the fundus, which provides information on the patient’s fixation pattern and the presence or absence of strabismus.

**INDICATIONS:**
Instrument-based vision screening using photoscreening and/or hand-held auto-refraction in the pediatric population with age appropriate, valid methods is considered to be medically necessary when the following criteria are met:

- The child is 6 months to 5 years of age, or
- The child is non-verbal up to age 21, and standard vision charts would be ineffective.

**EXCLUSIONS:**
The Plan does **NOT** provide coverage for ocular photoscreening for applications other than those listed under Indications because all other uses are considered **experimental, investigational or unproven** and **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

**CODING ASSOCIATED With Ocular Photoscreening**

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

- 99174: Ocular photoscreening with interpretation and report bilateral
- 99177: Instrument based ocular screening (e.g., photoscreening, automated-refraction), bilateral; with on-site analysis


**LINE OF BUSINESS:**
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

**REFERENCES:**


ECRI, HTAIS Target database (online), Ocular Photoscreening for early Diagnosis of Amblyopia, Media Opacities and Treatable Ocular Disease Processes. Published 12/6/2005


This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 10/12

**Revised:** 10/15 (Added Indications)

**Reviewed:** 10/13, 10/14; 10/16, 10/17, 10/18, 10/19