15

15 Eye Care Services

Medicaid pays for certain eye care services provided by participating Optometrists, Opticians, and Ophthalmologists.

Ophthalmologists may refer to Chapter 28, Physician, for additional information.

Medicaid also contracts with a Central Source contractor who is responsible for providing lenses and frames for Medicaid recipients. At the option of the provider taking the frame measurements, eyeglasses may be obtained from the Central Source or from any other source. Medicaid will pay no more than the contract price charged by the Central Source. Sample kits are available (frames and display containers) which can be purchased by eye care practitioners at the contractor's cost of frames plus mailing. Effective July 1, 2011, the Central Source contractor is Korrect Optical. Korrect Optical began accepting eyeglass orders on Tuesday, September 6, 2011.

Korrect Optical's phone number is 1-800-624-4225 and the website address is www.korrect.com.

NOTE:

Procedure Codes and prices are effective for dates of service 8/1/2011 and thereafter. Please refer to provider manuals prior to the October edition for information on prices for dates of service prior to 8/1/2011.

The policy provisions for eye care providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 17.

15.1 Enrollment

HP enrolls eye care providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as an Eye Care provider is issued a 10-digit National provider Identifier (NPI) that enables the provider to submit requests and receive reimbursements for eye care related claims.

A provider who contracts with Alabama Medicaid as an eye care provider is added to the Medicaid system with the NPI provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for eye care related claims.

NOTE:

All nine digits are required when filing a claim.

Opticians are assigned a provider type of 19. Optometrists are assigned a provider type of 18. Valid specialties for Eye Care providers include the following:

Optician (190)

Optometrist (180)

Ophthalmologists are enrolled with a provider type of 31 (Physician). The valid specialty is Ophthalmologist (330).

Enrollment Policy for Eye Care Providers

To participate in Medicaid, eye care providers must have current certification and be licensed to practice in the state of Alabama, allowed by their licensing board and the laws of State of Alabama.

To prescribe therapeutic agents for the eye, the optometrist must be appropriately licensed by the Alabama Board of Optometry.

Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:

(i) Eyeglasses,

(ii) Comprehensive Audiological services,

(iii) Comprehensive Ophthalmological services,

(iv) Patient 1st and EPSDT Referrals,

(g) Shall not bill Medicaid for services which are offered to anyone for free. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

15.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

This section also discusses the types of eye examinations covered by Medicaid and describes the standards and procedures used to provide eyeglasses.

NOTE:

The Agency establishes annual benefit limits on certain covered services. Benefit limits related to eye care services are established every three calendar years for recipients 21 years of age or older. Therefore, it is imperative for Eye Care Providers/Contractors furnishing services to recipients 21 years of age and older, to verify benefit limits for four calendar years (last 3 and current year) to determine if the eye care benefit limits have been exhausted. Providers/Contractors who do not verify benefit limits for four calendar years (last 3 years and current year) for recipients 21 years of age and older risk a denial of reimbursement for those services. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

NOTE:

Prior authorized (PA) frames, lenses, exams, and fittings are now posting to the benefit limits screen. It is imperative to verify eligibility and benefit limits prior to rendering services. Please refer to Chapter 3, Verifying Recipient Eligibility for details.

15.2.1 Examinations

Medicaid eye care providers may administer and submit claims for several kinds of examinations, including the following:

- Examination for refractive error
- Optometrist services other than correction of refractive error
- Physician services

Providers may render services to Medicaid recipients confined to bed in a health care facility if the patient's attending physician documents that the patient is unable to leave the facility and that the examination is medically necessary

Examination for Refractive Error

Medicaid recipients 21 years of age and older are authorized one complete eye examination and work-up for refractive error every three calendar years. Recipients under 21 years of age are authorized one complete eye examination and work-up for refractive error **each** calendar year **or** more often if indicated by documented evidence of medical necessity.

Complete Eye Examinations

The appropriate procedure codes to use when filing claims for a complete eye examination and refractive error work-up are codes 92004 and 92014.

A complete eye examination and refractive error work-up includes the following services:

- Case history review
- Eye health examination
- Visual acuity testing
- Visual fields testing (if indicated)
- Tonometry
- Eyeglasses prescription (if indicated)
- Determination of optical characteristics of the lenses (refraction)

Examiners use the appropriate diagnosis code(s) to indicate the diagnosis.

NOTE:

For children, examination of eye tension and visual fields should be performed only if indicated.

NOTE:

Procedure 92002 and 92012 **do not** count against the recipient's eye exam limits. However, these codes **will** count against the 14 annual physician office visit limit.

Please refer to Section 15.5.3 for additional information.

Optometrist Services

Optometrists may provide services other than correction of refractive error as follows:

- During an eye examination, if the optometrist suspects or detects irregularities requiring medical treatment that is not allowed by state law to be provided by an optometrist, the optometrist refers the case to an appropriate doctor of medicine or osteopathy.
- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Photochromatic lenses require prior authorization.
- Post-operative cataract patients may be referred, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Refer any subsequent abnormal or unusual conditions diagnosed during follow-up care back to the ophthalmologist.
- Artificial Eyes

NOTE:

All orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient’s name.

Physician Services

Physicians may provide the following eye care services when diseases, injuries, or congenital defects are present:

- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.
- Artificial Eyes

15.2.2 Eyeglasses

If a Medicaid recipient requires eyeglasses, services include verification of prescription, dispensing of eyeglasses, frame selection, procurement of eyeglasses, and fitting and adjustment of the eyeglasses to the patient.

Recipients 21 years of age and older are eligible for one pair of eyeglasses every three calendar years. Recipients under 21 years of age are authorized two pair of glasses each year if indicated by an examination, a prior authorization will be required for subsequent pairs requested in calendar year. These limitations also apply to fittings and adjustments.

Any exception to these benefit limits must be based on medical necessity and the reasons documented in the medical record. Examples of medical necessity could be for treatment of eye injury, disease, significant prescription change, or unrepairable damage to glasses. Additional eyeglasses cannot be authorized for convenience but only for clearly documented medically necessary reasons. An example for convenience may be more than one (1) pair of eyeglasses.

At the option of the provider taking the frame measurements, either the Central Source or any other source may provide eyeglasses that conform to Medicaid standards. Medicaid will pay no more than the contract price charged by the Central Source.

Frame Standards

See Section 15.5.3, Procedure Codes and Modifiers, for frame procedure codes and contract prices.

The authorized frames, or frames of equal quality, are provided for Medicaid recipients at the contract prices shown on the list. Under normal circumstances, the date of service for eyeglasses is the same as the date of examination. All frames must meet American National Standards Index (ANSI) standards.

Lens Standards

Lens specifications are authorized at the specified contract price. See Section 15.5.3, Procedure Codes and Modifiers, for lens procedure codes and contract prices.

Lenses are composed of clear glass, plastic or polycarbonate unless prior authorized by Medicaid because of unusual conditions. All lenses must meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements.

Spherical lenses must have at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (no other error) is 0.50 diopter.

New Lenses Only

Patients who have old frames that meet the above standards may have new lenses installed instead of receiving new eyeglasses. Medicaid will pay for the lens only.

Include the following statement in the patient’s record: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

New Frame Only

Patients who have old lenses that meet the above standards may have them installed in a new frame instead of receiving new eyeglasses.

Include the following statement on the patient's record: "I hereby certify that I used this patient's old lenses and that I did not accept any remuneration therefore."

Patient Requests Other Eyeglasses

If a patient chooses eyeglasses other than those provided by Medicaid, the patient must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for the patient's record: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

Additional Eye Exams or Eyeglasses for Recipients over 21 years of age

Medicaid may prior authorize additional eye exams and eyeglasses for recipients **over** 21 years of age only for medically necessary reasons such as eye injury, disease, or significant prescription change. The provider should forward an electronic PA request or an Alabama Prior Review and Authorization Request (Form 342) with a letter justifying necessity to HP prior to ordering the eyeglasses.

Additional Eye Exams or Eyeglasses for Recipients under 21 years of age

Medicaid may prior authorize additional eye exams and eyeglasses for recipients **under** 21 years of age for medically necessary reasons such as eye injury, disease, or significant prescription change, damage to glasses that cannot be repaired. Remember patients less than 21 years of age are authorized two pair of glasses each year if indicated by an examination. A prior authorization will be required for subsequent pairs requested in calendar year.

If this is a recent replacement and does not necessitate another eye exam, you are not required to perform another eye exam.

Replacement of Eyeglasses due to Warranty or Workmanship

If the replacement request is necessary due to warranty or workmanship reasons and it is within 90 days of the original issue of the eyeglasses, contact your eyeglass fabricating provider for replacement of the eyeglasses at no cost.

Ordering Frames, Lenses and Eyeglasses

As provided in Section 15.2.2 above, providers may order eyeglasses from the Central Source, Korrect Optical, or any other source that conforms to Medicaid standards.

NOTE:

When the Central Source provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the Central Source may submit claims for these services.

15.3 Prior Authorization and Referral Requirements

The Medicaid program requires that Medicaid give authorization prior to the delivery or payment of certain eye care services. Refer to Chapter 4, Obtaining Prior Authorization, for information about requesting prior authorization.

Prior authorization from Medicaid is required for the following eye care services:

- Lens and frame change in same benefit period
- Orthoptic training (eye exercises)
- Additional comprehensive exams in same benefit period
- Photochromatic lenses
- Low vision aids
- Contact lenses (for anisometropia, keratoconus, aphakia, and high magnification difference between lenses)
- Progressive Lenses

All requests for prior authorization should include the following information:

1. Recipient's name
2. Recipient's Medicaid Number (thirteen-digits)
3. If the PA is requested due to a prescription change, past and current prescription data (complete for both eyes), including diagnosis code(s), is required
4. Exception requested (what is being requested)
5. Reason for exception (explain, e.g., cataract surgery date, etc…), with current justification
6. Signature of practitioner
7. Address of practitioner

Refer to Section 15.5.3, Procedure Codes and Modifiers, for the appropriate procedure codes for services requiring prior authorization.

Other Situations

Providers may render special services for unusual situations upon prior authorization. Medicaid must receive full, written information justifying medical necessity prior to the service being rendered. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

Patient 1st Referral Requirements

The following ranges of procedure codes (including routine vision exams, eyeglasses, fittings, and lenses) **do not require a referral** for Patient 1st recipients:

Procedure Code	***Description***
V0100-V2799	CMS Assignment of Vision Services
V2020	Eyeglasses, Frames
V2025	Eyeglasses, Special Order Frames
92002-92015	Ophthalmological services for new or established patients

92313	Corneoscleral lens
92315-92317	Corneal lens/Corneoscleral lens
92326	Replacement of lens

Refer to Chapter 39, Patient 1st, for more information on Patient 1st requirements.

Eyeglass Contractors

If the Central Source provides eyeglasses, send them a copy of the approval letter from Medicaid bearing the prior authorization number.

15.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

* The following CPT codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:

90847, 90849, 90853, 90865, 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

15.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit

Eye care providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

This section explains how to file claims for the following situations:

- Eye examination only
- Eye examination and fitting by one provider, eyeglasses from the Central Source
- Fitting only, eyeglasses from the Central Source
- Post-operative care
- Ophthalmoscopy extended (92225) and subsequent (92226)
- Other situations

NOTE:

Providers who furnish services should only bill for those services provided. Please be aware when filing claims that the claim reflects services actually rendered/provided. Billing for services not provided could be considered fraudulent. Please ensure your billing staff is aware of appropriate billing practices.

Routine Checkups and Medicare

Medicare routinely covers eye care services for medical eye conditions (i.e. glaucoma, cataracts, diabetes, etc.). For dual eligibles (recipients with Medicare and Medicaid), Medicaid is the payer of last resort. For medical eye conditions, Medicare should be billed first for consideration of payment. Upon Medicare payment, the crossover form and information should be forwarded to HP for consideration of Medicaid payment. Should Medicare deny payment for a medical eye condition, seek all corrective Medicare remedies to ensure payment.

Medicare does not cover routine “Examination of Eyes and Vision” for a non medical reason. When non-medical and routine “Examination of Eyes and Vision” services are denied by Medicare, claims should be sent to the Medical Support unit at the Alabama Medicaid Agency within 120 days of the Medicare EOMB date. The claim must have Medicare denial attached. These claims require manual review for appropriateness and will be overridden when indicated.

Eye Examination Only

When the Medicaid recipient undergoes an eye examination only, the examiner completes a claim that specifies "Complete Eye Examinations and Refraction."

If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code or office visit code. Refer to 15.5.3, Procedure Codes and Modifiers, for a list of possible procedure codes. Send this claim directly to HP.

Eye Examination and Fitting by One Provider, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs an eye examination (including refraction) and fitting (including frame service, verification, and subsequent service) and the Central Source contractor provides the eyeglasses.

1. The examiner completes the CMS-1500 claim form, separately identifying the examination, refraction, and fitting. The examiner does not bill lenses and frames.
2. The examiner forwards the Medicaid job order form reflecting all necessary prescription data, including frame required, to the Central Source.
3. The contractor fills the prescription and returns the eyeglasses to the examiner for delivery to the patient. The Patient or Authorized Signature box must be complete with the appropriate signature or the statement "Signature on file."
4. The Central Source contractor submits claims for payment to HP.

When eyeglasses are NOT procured from the Central Source contractor, the claim should separately specify charges for the examination performed, refraction, fitting, lenses, and frame.

When Opticians provide eyeglasses, the claim should identify only the fitting service, lenses, and frame. The claim is sent directly to HP. Lenses and frames are reimbursed at the Central Source contract prices.

Fitting Only, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs a fitting (including frame service, verification, and subsequent service) and the Central Source contractor provides the eyeglasses.

The provider completes a claim that specifies the fitting services only. Send claims for payment directly to HP.

Post-Operative Care

Medicaid will not process post-operative management claims until the referring ophthalmologist has received payment for surgery. The surgeon must first submit a modifier 54 with the appropriate surgical code. The optometrist should then submit a modifier 55 with the appropriate surgical code after the ophthalmologist has been paid in order to be paid for post-operative care.

Medicaid will deny post-operative claims when the surgeon (ophthalmologist) receives payment for the global amount. It is the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.

NOTE:

The date of service for post operative care cannot be greater than 7 days after the global surgical procedure. For example, if the surgery was performed on 12/01, then the follow up must be performed on or before 12/8.

Ophthalmoscopy extended (92225) and subsequent (92226)

Ophthalmoscopy extended (92225) and subsequent (92226) are considered reasonable and necessary services for example, evaluation of tumors, retinal tears, detachments, hemorrhages, exudative detachments, retinal defects without detachment, and other ocular defects for the meticulous evaluation of the eye and detailed documentation of a severe ophthalmologic problem when photography is not adequate or appropriate. A serious retinal condition must exist, or be suspected, based on routine ophthalmoscopy which requires further detailed study. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. Accordingly, medical record documentation should be recorded in the patient's medical record.

15.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

15.5.2 Diagnosis Codes

The International Classification of Diseases Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

15.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed by Medicare

The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

This section lists procedure codes for optometric services and equipment arranged by type of service or equipment:

- Common Optometric services
- Special Optometric services
- Contact lenses
- Eyeglasses codes

Services requiring prior authorization are identified in the Prior Authorization column (PA required).

To report intermediate, comprehensive, and special services, use the specific ophthalmological description.

Common Optometric Services

The Optometric Services listed below are those commonly used by Optometrists and Ophthalmologists. Procedure codes 92004 and 92014 should include a complete eye exam and work-up as outlined in Section 15.2.1.

Procedure Code	***Description***
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Comprehensive, established patient, one or more visits
92015	Determination of refractive state (Bill as an add-on charge with complete eye exam when refraction is accomplished)
99201	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A problem-focused history • A problem-focused examination; and • Straightforward medical decision making
99202	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components • An expanded problem-focused history • An expanded problem-focused examination; and • Straightforward medical decision making
99203	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A detailed history • A detailed examination; and • Medical decision making of low complexity
99204	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of moderate complexity

Procedure Code	*Description*
99205	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of high complexity
99211	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A problem-focused history • A problem-focused examination • Straightforward medical decision making
99213	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • An expanded problem-focused history • An expanded problem-focused examination • Medical decision making of low complexity
99214	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A detailed history • A detailed examination • Medical decision making of moderate complexity
99215	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity

Miscellaneous Procedures

Procedure Code	*Description*
99241	Office consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99242	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making
99251	Inpatient consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99252	Inpatient consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making

Special Optometric Services

Procedure Code	*Description*	*PA Required*
92018	Opthalmological examination and evaluation under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic evaluation	No
92019	Limited	No
92020	Gonioscopy (separate procedure)	No
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	No
92065	Orthoptic training and/or pleoptic training, with continuing medical direction and evaluation (requires prior authorization from Medicaid)	Yes
92071	Fitting of contact lenses for treatment of ocular surface disease	No
92072	Fitting of contact lenses for management of keratoconus, initial fitting	No
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent) For children: examination of eye tension and visual fields should be performed only if indicated.	No
92082	Intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	No
92083	Extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 300	No
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)	No
92136	Opthalmic biometry by partial coherence interferometry with intraocular lens power calculation	No
92140	Provocative tests for glaucoma, with interpretation and report, without tonography	No
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	No
92226	Subsequent	No
92230	Florescein angioscopy with interpretation and report	No
92250	Fundus photography with interpretation and report	No
92260	Opthalmolodynamometry	No
92270	Electro-oculography with interpretation and report	No
92275	Electroretinography with interpretation and report	No
92283	Color vision examination extended, e.g., anomaloscope or equivalent	No
92284	Dark adaptation examination with interpretation and report	No
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	No
92340	Fitting of spectacles, except aphakia; monofocal	No
92341	Bifocal	No

Procedure Code	Description	PA Required
92342	Multifocal, other than bifocal	No
92352	Fitting of spectacle prosthesis for aphakia; Monofocal	No
92353	Multifocal	No
92354	Fitting of spectacle mounted low vision aid; single element system	No
92355	Telescopic or other compound lens system	No
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	No
92370	Repair and refitting spectacles; except for aphakia	No
92371	Spectacle prosthesis for aphakia	No

Surgical Procedures

Procedure Code	Description
65205*	Removal of foreign body, external eye; conjunctival superficial
65210*	Conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220*	Corneal, without slit lamp
65222*	Corneal, with slit lamp
68801*	Dilation of lacrimal punctum, with or without irrigation
68810*	Probing of nasolacrimal duct, with or without irrigation

* Service Includes Surgical Procedure Only

Post Operative Care Modifiers

Use the appropriate modifier identifying post-operative management when submitting claims.

1st Modifier	Description
55	Postoperative Management (Optometrist)
54	Surgical Care (Opthamologist)
2nd Modifier	**Description**
RT	Right Eye
LT	Left Eye

Contact Lenses

Contact lenses may be provided for post-cataract surgery, anisometropia, keratoconus treatment, and high magnification difference between lenses. Fitting services are billed as a separate billed item. Lenses are billed per lens. Prior authorization is required for lenses and fitting services.

Procedure Code	Modifier, If Applicable	Description	PA Required
V2501		Contact lens, PMMA, toric or prism ballast	Yes
V2502		Contact lens, PMMA, bifocal	Yes
V2503		Contact lens, PMMA, color vision deficiency	Yes
V2510		Contact lens, gas permeable, spherical	Yes
V2511		Contact lens, gas permeable, toric	Yes
V2512		Contact lens, gas permeable, bifocal, per lens	Yes
V2513		Contact lens, gas permeable, extended wear	Yes
V2520		Contact lens, hydrophilic, spherical	Yes
V2521		Contact lens, hydrophilic, toric	Yes
V2522		Contact lens, hydrophilic, bifocal	Yes

Procedure Code	Modifier, If Applicable	Description	PA Required
V2501		Contact lens, PMMA, toric or prism ballast	Yes
V2502		Contact lens, PMMA, bifocal	Yes
V2503		Contact lens, PMMA, color vision deficiency	Yes
V2523		Contact lens, hydrophilic, extended wear	Yes
V2530		Contact lens, sclera, gas impermeable	Yes
V2531		Contact lens, gas permeable	Yes
V2599		Contact lens, other type	Yes
92310	52	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	Yes
92311		Corneal lens for aphakia, one eye	Yes
92312		Corneal lens for aphakia, both eyes	Yes
92313		Corneoscleral lens	Yes
92314		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	Yes
92315		Corneal lens for aphakia, one eye	Yes
92316		Corneal lens for aphakia, both eyes	Yes
92317		Corneoscleral lens	Yes
92325		Modification of contact lens (separate procedure), with medical supervision of adaptation	No
92326		Replacement of contact lens	Yes

Eyeglasses Codes

NOTE:

Procedure Codes and prices are effective for dates of service 8/1/2011 and thereafter. Please refer to provider manuals prior to the October edition for information on prices for dates of service prior to 8/1/2011.

At the option of the provider making the frame measurements, eyeglasses that conform to Medicaid standards may be procured from either the Central Source or from any other source. However, Medicaid will pay only the contract price charged by the Central Source.

Use the procedure codes and prices listed below for lenses. Add-on lens treatments requiring prior authorization are listed separately.

The lens specifications below are authorized at the specified contract price. Lenses must meet FDA impact-resistant regulations and must be made of glass or clear plastic except when other materials are prior authorized by Medicaid for unusual conditions. Spherical lenses must be at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (with no other error) is 0.50 diopter.

Procedure codes are listed in the following order:
Lens Codes

- Single vision sphere
- Single vision spherocylinder
- Bifocal sphere
- Bifocal spherocylinder

- Trifocal sphere
- Trifocal spherocylinder
- Variable Asphericity Lens
- Other lenses
- Lenses requiring prior authorization from Medicaid before ordering.

Single Vision Sphere (Plus or Minus)

Single Vision (Plus or Minus)	*Price Per Lens*
V2100 – Plano +/- 4.00	$11.00
V2101 – +/- 4.12 +/- 7.00d	11.00
V2102 – +/- 7.12 +/- 20.00d	13.00

Single Vision Spherocylinder (Plus or Minus)

Single Vision (Plus or Minus)	*Price Per Lens*
V2103 – Plano +/- 4.00d sphere, 0.12 – 2.00d cylinder	11.00
V2104 – Plano +/- 4.00d sphere, 2.12 – 4.00d cylinder	11.00
V2105 – Plano +/- 4.00d sphere, 4.25 – 6.00d cylinder	11.00
V2106 – Plano +/- 4.00d sphere, over 6.00d cylinder	13.00
V2107 – +/- 4.25 +/- 7.00 sphere, 0.12 – 2.00d cylinder	11.00
V2108 – +/- 4.25d +/- 7.00d sphere, 2.12 – 4.00d cylinder	11.00
V2109 – +/- 4.25 +/- 7.00d sphere, 4.25 – 6.00d cylinder	13.00
V2110 – +/- 4. 25– 7.00d sphere, over 6.00d cylinder	13.00
V2111 – +/- 7.25 +/- 12.00d sphere, 0.25 – 2.25d cylinder	13.00
V2112 –+/- 7.25 +/- 12.00d sphere, 2.25d – 4.00d cylinder	13.00
V2113 – +/- 7.25 +/- 12.00d sphere, 4.25 – 6.00d cylinder	13.00
V2114*– over plus or minus 12.00d	13.00
V2199 – Not otherwise classified	15.00

Bifocal Sphere (Plus or Minus)

Bifocal Sphere (Plus or Minus)	*Price Per Lens*
V2200 – Plano +/- 4.00d	$12.00
V2201 – +/- 4.12 +/- 7.00d	14.00
V2202 – +/- 7.12 +/- 20.00d	7.62

Bifocal Spherocylinder (Plus or Minus)

Bifocal Spherocylinder (Plus or Minus) Cylinder	*Price Per Lens*
V2203 – Plano – +/- 4.00d/0.12 – 2.00d cylinder	$12.00
V2204 – Plano – +/- 4.00/2.12 – 4.00d cylinder	12.00
V2205 – Plano – +/- 4.00 sphere, 4.25 – 6.00d cylinder	14.00
V2206 – Plano – +/- 4.00d sphere over 6.00d cylinder	14.00
V2207 – +/- 4.25 +/- 7.00d sphere, 0.12 – 2.00d cylinder	12.00
V2208 – +/- 4.25 +/- 7.00d sphere, 2.12 – 4.00d cylinder	14.00
V2209 – +/- 4.25 +/- 7.00d sphere, 4.25 – 6.00d cylinder	14.00
V2210 – +/- 4.25 +/- 7.00d sphere over 6.00d cylinder	25.00
V2211 – +/- 7.25 +/- 12.00d sphere, 0.25 – 2.25d cylinder	14.00
V2212 – +/- 7.25 +/- 12.00d sphere, 2.25 – 4.00d cylinder	14.00
V2213 – +/- 7.25 +/- 12.00d sphere, 4.25 – 6.00d cylinder	14.00
V2214* –over plus or minus 12.00d	14.00

Trifocal Sphere (Plus or Minus)

Bifocal Sphere (Plus or Minus)	*Price Per Lens*
V2300 – Sphere Plano- +/- 4.00d	$25.00
V2301 – Sphere- +/- 4.12 - +/- 7.00d	25.00
V2302 – Sphere Plano- +/- 7.12 - +/- 20.00	25.00

Trifocal Spherocylinder (Plus or Minus)

V2303 – Spherocylinder Plano +/- 4.00d sphere 0.12-2.00d cylinder	25.00
V2304 – Spherocylinder Plano +/- 4.00d sphere 2.25 – 4.00d cylinder	25.00
V2305 – Spherocylinder Plano +/- 4.00d sphere 4.25 – 6.00d cylinder	25.00
V2306 – Spherocylinder Plano +/- 4.00d/over 6.00d cylinder	25.00
V2307 – Spherocylinder +/- 4.25 +/- 7.00d sphere 0.12 – 2.00d cylinder	25.00
V2308 – Spherocylinder +/- 4.25 +/- 7.00d sphere 2.12 – 4.00d cylinder	25.00
V2309 – Spherocylinder +/- 4.25 +/- 7.00d sphere 4.25 – 6.00d cylinder	25.00
V2310 – Spherocylinder +/- 4.25 +/- 7.00d sphere over 6.00d cylinder	25.00
V2311 – Spherocylinder +/- 7.25 +/- 12.00d sphere 0.25 – 2.25d cylinder	25.00
V2312 – Spherocylinder +/- 7.25 +/- 12.00d sphere 2.25 – 4.00d cylinder	25.00
V2313 – Spherocylinder +/- 7.25 +/- 12.00d sphere 4.25 – 6.00d cylinder	25.00
V2314 - Spherocylinder trifocal Over +/- 12.00d	25.00

Varible Asphericity Lens

Variable Asphericity Lens	*Price Per Lens*
V2410 – Variable asphericty lens, single vision	$10.00
V2430 – Variable sphericity lens, bifocal	$10.00

Other Lenses

Other	*Price Per Lens*
V2115 – Lenticular (Myodisc)	$14.00
V2118 - Aniseikonic lens, single vision	40.00
V2121 – Lenticular lens, per lens, single	13.00
V2215 - Lenticular (Myodisc) Bifocal	30.00
V2218 – Lens Aniseikonic Bifocal	30.00
V2219 – Lens Bifocal Seg Width Over 28mm	5.00
V2220 – Bifocal add over 3.25d	10.00
V2221 – Lenticular lens, per lens, bifocal	30.00
V2299 –Specialty Bifocals see note box below	14.00
V2315 – Lenticular, (myodisc), per lens, trifocal	35.00
V2318 – Aniseikonic lens, trifocal	35.00
V2319 – Trifocal seg width over 28 mm	5.00
V2320 – Trifocal add over 3.25d	10.00
V2321 – Lenticular lens, per lens, trifocal	35.00
V2399 – Specialty Trifocals see note box below	25.00
V2499 – Variable Asphericity	10.00

Other	*Price Per Lens*
V2700 – Balance lens	10.00
V2710 – Slab-off Prism**	30.00
V2715 – Prism**	0.00
V2718 – Press On Fresnell Prism **	30.00
V2745 – Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic**	0.00
V2755 – UV 400 Coating**	0.00
V2784 – Polycarbonate Lenses, or equal**	0.00

NOTE:

1. Effective August 1, 2011 Procedure Code V2784 (Polycarbonate Lens) is an add-on code and should be billed in addition to another lens code for the same eye.
2. Medical record documentation should support the medical appropriateness of billing procedures V2299 and/or V2399. These services are subject to post payment review.

Lenses Requiring Prior Authorization from Medicaid Before Ordering

Lens	*Price per Lens*
V2744 – Tint, Photochromatic **	$25.00
V2781 - Progressive Lens - CR-39** (effective July 1, 2002)	10.00
V2782 - Lens, Index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate **	10.00
V2783 - Lens, Index >1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate **	20.00

**** Add-on Cost**: This item to be billed in addition to appropriate lens code.

Frames

The frame specifications below are authorized at the specified contract price.

Effective July 1, 2002, the locally assigned procedure codes for frames are converted to one of two codes (PC), V2020 and V2025.

A special order frame is designated as V2025 and effective for dates of service 8/1/2011 and thereafter should be billed as $100.00.

Procedure code V2020 is designated for all the other frame codes and effective for dates of service 8/1/2011 and thereafter; $0.00 should be billed.

NOTE:

As of 8/1/2011, the price of the frame is included in the cost of the lens. Therefore, frames are zero priced.

For the available selection of frames, please refer to Korrect Optical's website at www.korrect.com.

Special Order Frame (Size, Type) - Providers should bill the price of the frame in this manual and not their usual and customary price for the frame

Frame	*Code Description*	*Price*
V2025	Special Order Frames ***(PA REQUIRED)***	$100.00

15.5.4 Place of Service Codes

The following place of service codes apply when filing claims for eye care services:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility

15.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances.

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

15.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.7.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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