



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Vision Services

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Revision History

| Version | Date | Reason for Revisions | Completed By |
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| 1.0 | Policies and procedures as of October 1, 2015 Published: February 25, 2016 | New document | FSSA and HPE |
| 1.1 | Policies and procedures as of April 1, 2016 Published: December 15, 2016 | Semiannual update: <ul style="list-style-type: none"> • Reorganized and edited text throughout for clarity • Added a note box for managed care contact information • Added a note box with information regarding maintaining documentation of medical necessity • Deleted “Fitting for contact lenses” from the list of bundled services in the Coverage and Billing for Vision Services section • Corrected codes listed in the Eye Examinations section • In the Frames section, updated documentation requirements and reimbursement factors for medically necessary deluxe frames (V2025) | FSSA and HPE |
| 1.2 | Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 28, 2017 | <ul style="list-style-type: none"> • Replaced Automated Voice Response (AVR) system references with Interactive Voice Response (IVR) system • Replaced Web interChange references with Provider Healthcare Portal (Portal) • Updated claim references to reflect Portal billing options • Updated the Written Correspondence section to include information about submitting coverage inquiries through the Portal and revised time frame for response | FSSA and HPE |

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Note: For policy information regarding coverage of vision services, see the [Medical Policy Manual](#) at [indianamedicaid.com](#).

Introduction

Vision services are provided to Indiana Health Coverage Programs (IHCP) members as described in this document. Vision services must be provided by an ophthalmologist or an optometrist within the scope of their licensure.

Ophthalmologists are licensed medical physicians or osteopathic physicians with the ability and credentials to perform surgical procedures on the eye and related structures. Optometrists are licensed professionals trained to examine eyes and vision, prescribe and fit lenses, and diagnose and treat visual problems or impairment.

Other vision-related services such as pharmaceutical, surgeries, and diabetes self-management training are covered services when determined to be medically necessary.

Note: The IHCP makes vision services available to Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members on a self-referral basis. For managed care members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at [indianamedicaid.com](#).

Reimbursement Requirements for Vision Services

The IHCP provides reimbursement for ophthalmology services, subject to the following restrictions:

- Allows one routine vision care examination and refraction for members 20 years old and younger, per rolling calendar year
- Allows one routine vision care examination and refraction for members 21 years old and older, every two years
- Provides eyeglasses (including replacement eyeglasses) only when the following medical necessity guidelines are met in at least one eye:
 - A change of 0.75 diopters for members 6 to 42 years old
 - A change of 0.50 diopters prescription or change for members more than 42 years old
 - An axis change of at least 15 degrees
- Provides replacement frames and lenses only when the medical necessity guidelines are met or when necessitated by loss, theft, or damage beyond repair
- Allows one pair of eyeglasses per year for members 20 years old and younger
- Allows one pair of eyeglasses every five years for members 21 years old and older

Note: If medical necessity dictates more frequent examination or care, documentation of such medical necessity must be maintained in the provider's office.

Prior Authorization for Vision Services

The IHCP does not require prior authorization (PA) for vision care services except for the following provisions:

- Blepharoplasty for a significant obstructive vision problem
- Prosthetic device, except eyeglasses
- Reconstruction or plastic surgery
- Retisert

For general information about requesting prior authorization, see the [Prior Authorization](#) module.

Coverage and Billing for Vision Services

Providers must use the appropriate Current Procedural Terminology (CPT^{®1}) codes or Healthcare Common Procedure Coding System (HCPCS) codes when submitting claims for vision services to the IHCP. The IHCP reimburses opticians and optometrists only for services listed in their respective provider specialty code sets. Optician and optometrist code sets are available in *Vision Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

The IHCP considers the following services bundled and not separately billable to the IHCP or the patient:

- Eyeglass cases
- Fitting of eyeglasses
- Neutralization of lenses
- Verification of prescription

Note: All claims must reflect a date of service. The date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For example, when providing glasses for a member, the date of service would reflect the date the member received the glasses. This requirement is applicable to all IHCP-covered services.

Vision Procedures Limited to One Unit

See *Vision Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a list of procedure codes for which IHCP providers may bill only one unit per member, per day. Claims that have more than one unit per day for these codes automatically cut back and pay for one unit. Providers that have been reimbursed for more than one unit may be subject to postpayment review and possible recoupment.

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Eye Examinations

Providers should use the CPT code that best describes the examination to report eye examinations. The CPT codes for eye examinations, including counseling and coordination, are as follows:

- 92002–92014
- 99201–99205
- 99211–99215
- 99341–99345
- 99347–99350

The eye examination includes the following services, and providers should not bill separately for these:

- Biocular measurement
- External eye examination
- Gross visual field testing including color vision, depth perception, or stereopsis
- Routine ophthalmoscopy
- Tonometry
- Visual acuity determination

Providers may code examinations in which counseling and coordination of care are the dominant services with the appropriate evaluation and management (E/M) code, using the time factor associated with the code. Documentation in the patient's record must include the total time of the encounter and a synopsis of the counseling topics and coordination of care efforts.

The IHCP reimburses provider specialty 180 – *Optometrists* for CPT code 95930 – *Visual evoked potential (VEP) testing central nervous system, checkerboard or flash* when billed with one of the diagnosis codes listed in *Vision Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Providers can submit the following diagnostic services, if medically necessary, in addition to the eye examination:

- Dark adaptation examination
- Determination of a refractive state
- Extended color vision examination
- External ocular photography and special anterior segment photography
- Fitting of contact lens for treatment of disease, limited visual field, intermediate visual field, extended visual field, serial tonometry, and tonography
- Gonioscopy
- Orthoptic or pleoptic training
- Provocative tests for glaucoma, extended ophthalmoscopy, fluorescein angiography, indocyanine-green angiography, fundus photography, ophthalmodynamometry, needle oculoelectromyography, and electroretinography
- Scanning computerized ophthalmic diagnostic imaging
- Sensorimotor examination

Orthoptic or Pleoptic Training, Vision Training, and Therapies

CPT code 92065 – *Orthoptic and/or pleoptic training, with continuing medical direction and evaluation* covers all vision training therapies. Providers should meet the following criteria:

- Vision therapy services must be billed using CPT code 92065, which is limited to one unit or visit per day.
- A physician or an optometrist must order all vision therapy services.
- The physician or optometrist must document, in the member’s medical record, a diagnosis and treatment plan and the need for continued treatment.
- An optometrist, a physician, or a supervised staff that is certified or trained to provide these services can perform vision therapy services.
- Staff trained or certified in vision training may perform orthoptic and pleoptic training *only* under the *direct supervision* of an optometrist or physician. Direct supervision requires the supervising physician or optometrist must be physically available at the time and the place where the vision therapy services are rendered.
- *Only* the supervising optometrist or physician may document the treatment plan and reevaluations in the medical record. All documentation of directly supervised vision therapy services rendered by opticians, orthoptists, or staff trained in vision therapy must be **cosigned** by the supervising optometrist or physician in the medical record.

These services are noncovered by Medicare. For dually eligible members (those with both Medicare and Full Medicaid coverage), providers can bill these services directly to the IHCP on a professional claim (CMS-1500 claim form, Provider Healthcare Portal [Portal] professional claim, or 837P electronic transaction). Medicare noncovered services are not covered by the IHCP for members who have only Qualified Medicare Beneficiary coverage (known as QMB Only members). For members with both Qualified Medicare Beneficiary and also Full Medicaid coverage (known as QMB Also members), follow guidelines in the [Third Party Liability](#) module.

Lenses

Providers should include prescription of lenses, when required, in CPT code 92015 – *Determination of refractive state*, which includes specification of lens type (monofocal, bifocal, or other), lens power, axis, prism, absorptive factor, impact resistance, and other factors.

The IHCP does not provide coverage for all lenses. If a member chooses to upgrade to progressive lenses, transitional lenses, antireflective coating, or tint numbers other than 1 and 2, providers can bill the basic lens V code to the IHCP. Providers can bill the upgrade portion to the member only if they gave the member appropriate advance notification of noncoverage.

According to *Indiana Administrative Code 405 IAC 5-23-4 (2)*, the IHCP may only reimburse for tints 1 and 2, billed with the following procedure code and modifiers:

- V2745 U1 – *Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens, plastic, rose 1 or 2, per lens*
- V2745 U2 – *Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens, glass, rose 1 or 2, per lens*

The IHCP covers safety lenses only for corneal lacerations and other severe intractable ocular or ocular adnexal disease.

Polycarbonate Lenses

The IHCP developed specific criteria for polycarbonate lenses to ensure that providers use the lenses only for medically necessary conditions requiring additional ocular protection for members. HCPCS code V2784 – *Lens, polycarbonate or equal, any index, per lens* remains covered when a corrective lens is medically necessary, and if one or more of the following criteria is met:

- Member has carcinoma in one eye, and the healthy eye requires a corrective lens.
- Member has only one eye that requires a corrective lens.
- Member had eye surgery and still requires the use of a corrective lens.
- Member has retinal detachment or is postsurgery for retinal detachment and requires a lens to correct a refractive error of one or both eyes.
- Member has a cataract in one eye or is post-cataract-surgery, and requires a lens to correct a refractive error of one or both eyes.
- Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye.
- Other conditions deemed medically necessary by the optometrist or ophthalmologist exist. These conditions must be such that one eye is affected by an intractable ocular condition, and the polycarbonate lens is being used to protect the remaining vision of the healthy eye.

In all these situations, one or both eyes must be affected by an intractable ocular condition. The IHCP covers the polycarbonate lens only to protect the remaining vision of the healthy eye when it is medically necessary to correct a refractive error. Patient charts must support medical necessity. The IHCP monitors use of these lenses in postpayment reviews.

Contact Lenses

The IHCP covers contact lenses when they are medically necessary. The IHCP does not require documentation with the claim, but providers must maintain documentation in the patient's medical record for postpayment review. Examples of medically necessary contact lenses include, but are not limited to, patients with severe facial deformity who are physically unable to wear eyeglasses or who have severe allergy to all frame materials. The prescription of contact lens includes the specification of optical and physical characteristics such as power, size, curvature, flexibility, and gas permeability, and providers can bill with CPT codes 92310 through 92326, which are not part of the general ophthalmology services. Fitting contact lenses includes instruction and training of the wearer and incidental revision of the lenses during the training period. Providers should report follow-up of successfully fitted extended wear lenses as part of the general ophthalmological service.

Frames

The IHCP reimburses for frames including, but not limited to, plastic or metal. Providers should bill for frames using procedure code V2020. Providers that receive payment from the IHCP for frames may not bill the member for any additional cost above the IHCP reimbursement. The maximum amount reimbursed for frames is \$20 per pair, except when medical necessity requires a more expensive frame. Situations include, but are not limited to:

- Special frames to accommodate a facial deformity or anomaly
- Frames with special modifications, such as a ptosis crutch
- Allergy to standard frame materials
- Frames for an infant or child where special-size frames that are unavailable for \$20 or less must be prescribed

All claims for more expensive frames must be accompanied by documentation supporting medical necessity. Providers **must** submit a manufacturer's suggested retail price (MSRP) or cost invoice and charges for medically necessary deluxe frames with procedure code V2025. The IHCP reimburses medically necessary deluxe frames at 75% of the MSRP or 120% of the cost invoice.

The IHCP does not cover any portion of a deluxe or fancy frame purchase, except when medically necessary. If a member chooses to upgrade to a deluxe frame, the IHCP considers the entire frame noncovered, and the provider may bill it to the member, if the provider gave proper advance notice of no coverage to the member and the member signed it. In these situations, providers should submit only the claim for the lenses to the IHCP.

The IHCP does not cover the following services:

- Lenses with decorative designs
- Fashion tints, gradient tints, sunglasses, and photochromatic lenses
 - The IHCP does cover tint numbers 1 and 2, rose A, pink 1, soft lite, cruxite, and velvet lite, subject to medical necessity.
- Oversized lenses larger than 61mm, except when medical necessity is documented

The IHCP reimburses for lenses and other optical supplies, except frames, at the lower of the provider's usual and customary charge or the IHCP maximum rate on file.

Replacement Eyeglasses

Repair or replacement covers the part of the eyeglasses that is broken or damaged. Patients are **not** entitled to a new pair of eyeglasses if the lenses or frames can be repaired. To bill for repair of glasses, the U8 modifier must be used.

Members younger than 21 years of age who have met the medical necessity for replacement eyeglasses may be eligible for a new pair of eyeglasses one year from the date when the IHCP provided their replacement eyeglasses. Members 21 years of age and older who have met the medical necessity for replacement eyeglasses may be eligible for a new pair of eyeglasses five years from the date when the IHCP provided their replacement eyeglasses.

Note: Replacement of eyeglasses beyond the indicated criteria must be medically necessary and clearly documented in the patient's medical record. Replacement eyeglasses represent the beginning of a new limitation period.

Providers must include documentation in the member's medical record to substantiate the need for replacement frames or lenses. Documentation that eyeglasses have been lost, stolen, or broken beyond repair must include a signed statement by the member detailing how the eyeglasses were lost, stolen, or broken.

The IHCP requires modifiers on claims for replacement of frames or lenses within the one- or five-year period, based on the patient's age at the time of service:

- If a member needs replacement eyeglasses before the established frequency limitations due to loss, theft, or damage beyond repair, providers must use the U8 modifier to bill for the replacement lenses or frames.
- If a member needs replacement eyeglasses before the established frequency limitations due to a change in prescription, as specified in 405 IAC 5-23-4(7), providers must use modifier SC when billing lenses or frames.

Use of either modifier indicates that the appropriate documentation is on file in the patient's record to substantiate the need to replace lenses or frames. These modifiers are not needed on claims for replacement of frames or lenses within the established frequency limitations; however, all eyeglasses dispensed must meet the minimum prescription requirements for the initial dispensing and each subsequent dispensing of eyeglasses. Replacement of eyeglasses must be for medical necessity.

Corneal Tissue

The cost associated with corneal tissue acquisition, HCPCS code V2785 – *Processing, preserving, and transporting corneal tissue*, is separately reimbursable from the ambulatory surgical center (ASC) rate for outpatient corneal transplant procedures. Submit claims for this item on the professional claim (*CMS-1500* claim form or electronic equivalent). Make sure to attach a copy of the invoice from the eye bank or organ procurement organization showing the actual cost of acquiring the tissue. Providers must follow current policy for submitting paper attachments with the 837P transaction. HCPCS code V2785 is reimbursed 100% of the cost invoice.

Intraocular Lenses

New technology intraocular lenses (NTIOL) are intraocular lenses (IOLs) that the Centers for Medicare & Medicaid Services (CMS) has identified as being superior to other IOLs of the same category, because of a demonstrated decrease in postoperative complications. Providers should use the appropriate HCPCS V-code.

Any facility reimbursed at an ASC rate should submit claims for surgical insertions of IOLs using the physician's CPT code 66983, 66984, 66985, or 66986 and the appropriate revenue code on an institutional claim (*UB-04* claim form, Portal institutional claim, or 837I electronic transaction). The NTIOL claim must be submitted on a separate professional claim (*CMS-1500* claim form or electronic equivalent) using the facility's DME NPI.

Triamcinolone Acetonide

The IHCP provides coverage for ophthalmologic use of HCPCS code J3300 – *Injection, triamcinolone acetonide, preservative free, 1 mg*. The IHCP recognizes that triamcinolone acetonide, preservative free, is distributed in single-dose vials of 40 mg and some wastage of the product may be unavoidable. Thus, IHCP providers may bill the entire 40 mg in cases in which less than 40 mg are injected in a single treatment session, and the balance of the product is discarded. Whenever unused triamcinolone acetonide, preservative free is billed, both the amount of the agent actually administered and the amount discarded are to be documented in the member's medical record. IHCP reimbursement for J3300 is limited to 40 mg per date of service.

If an E/M code is billed with the same date of service as office-administered therapy, the administration should not be billed separately. Reimbursement for the administration is included in the E/M code-allowed amount. Separate reimbursement is allowed when the administration is the only service provided and billed by the practitioner.

Approved indications for J3300 are limited to ophthalmologic use. A similar code, J3301 – *Injection, triamcinolone acetonide, not otherwise specified 10mg* may be used for nonophthalmologic purposes.

Intraocular Stents

The IHCP covers intraocular stents inserted in conjunction with cataract surgery. For dates of service on or after August 14, 2015, the following CPT codes will be covered for all IHCP programs, subject to limitations established for certain benefit packages:

- 0191T – *Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork*
- 0376T – *Insertion of eye drainage device*

Use CPT code 0191T for the initial stent, and CPT code 0376T for any additional stent that may be required in the same eye. Both codes must be billed with cataract surgery CPT codes 66982, 66983, 66984, or 66985.

Retisert

For dates of service on or after August 1, 2015, the IHCP covers HCPCS code J7311 – *Fluocinolone acetonide, intravitreal implant (Retisert®)* for the treatment of chronic posterior uveitis. Retisert should not be billed for diabetic macular edema. J7311 is limited to one unit per date of service, and must be billed with the appropriate National Drug Code (NDC). Coverage applies to all IHCP programs, subject to prior authorization and to limitations established for certain benefit packages.

Vision Benefit Limits

Benefit limits for vision services are available through the Eligibility Verification System (EVS). For more information on the EVS options, see the [Electronic Data Interchange](#), [Interactive Voice Response System](#), and [Provider Healthcare Portal](#) modules.

Note: For managed care members, contact the appropriate MCE for information about a member's vision service limitations.

Written Correspondence

Ophthalmology and optometric providers may not have the most current information available about services previously rendered to a member and paid by the IHCP. This situation can result in reduced reimbursement or no reimbursement for rendered services. Providers may submit secure correspondence through the Portal or write to the Written Correspondence Unit to inquire whether particular members have exceeded their service limitations. Providers should allow up to four business days for a response (plus delivery time, for inquiries sent by mail).

To assist analysts in researching the issue and providing a resolution, providers should clearly state the reason for the inquiry. The Written Correspondence Unit may need to contact the provider for additional information if the inquiry submitted is incomplete. Providers should not send inquiries to resubmit claims previously rejected.

To submit an inquiry through the Portal, providers can create a secure correspondence message using the Coverage Inquiry category. For information about registering to use the Portal and submitting secure correspondence via the Portal, see the [Provider Healthcare Portal](#) module.

For inquiries sent via mail, providers should use the *Indiana Health Coverage Programs Inquiry Form*, available from the [Forms](#) page at indianamedicaid.com, to ensure that complete information is sent in the inquiry. Mail written inquiries to the following address:

Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

Billing a Member for Services that Exceed Benefit Limits

Providers may bill IHCP members for services exceeding the ophthalmology benefit limitations under the following circumstances:

- If the EVS informs the provider the limitation has already been met, and the member is informed. If the member still wishes to receive the service, he or she is asked to sign a waiver stating the service will not be covered because benefits have been exhausted.
- If the EVS does not show benefits have been exhausted, the provider may ask the member or their guardian to attest in writing they have not received Medicaid-covered glasses within the past one or five years (depending upon their age). The member is informed that if they are misrepresenting and the provider's claim is denied for exceeding benefit limitations, the member will be responsible for the charges.