INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Vision Services

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Revision History

Version	Date	Reason for Revisions	Completed By
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	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: March 28, 2017	*Core*MMIS updates	FSSA and HPE
2.0	Policies and procedures as of April 7, 2017 Published: October 26, 2017	Scheduled update: • Reorganized and edited text as needed for clarity • Clarified restrictions in the *Coverage and Restrictions for Vision Services* section • Removed outdated claim-processing information in the *Vision Procedures Limited to One Unit* section • Clarified coverage in the *Eye Examinations* section • Replaced the list of services with a reference to the IAC and *Medical Policy Manual* in the *Diagnostic Services* section • Added medical necessity guidelines and updated reimbursement information in the *Eyeglasses* section • Updated instructions for providers to bill the upgrade portion to the member in the *Lenses* section • Updated reimbursement information in the *Frames* section • Updated billing instructions in the *Replacement or Repair of Eyeglasses* section • Clarified proper use of the billing codes in the *Contact Lenses* section	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		• Added Portal instructions for attachments the *Corneal Tissue* section • Updated billing instructions in the *Intraocular Lenses* section • Moved intraocular stent codes to the V*ision Services Codes* document and placed reference in the *Intraocular Stents* section • Added EVS options to the *Vision Benefit Limits* section and clarified that EVS information is for FFS claims only	

Table of Contents

> *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, and subject to limitations established for certain benefit packages. Ophthalmology 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 services, surgeries, and diabetes self-management training, are covered services when determined to be medically necessary.

The IHCP makes routine vision services available to managed care members on a self-referral basis.

> *Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise 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.*

Coverage and Restrictions for Vision Services

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

- Allows one routine vision care examination and refraction for members younger than 21 years old, per 12-month period
- 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:
  - A minimum initial prescription (or, for a subsequent pair of glasses, a minimum change) of 0.75 diopters in at least one eye for members 6 to 42 years old
  - A minimum initial prescription (or, for a subsequent pair of glasses, a minimum change) of 0.50 diopters in at least one eye 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 younger than 21 years old
- 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.

Billing and Reimbursement 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.

For all services, coverage is subject to limitations established for certain benefit plans.

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. Providers that have been reimbursed for more than one unit may be subject to postpayment review and possible recoupment.

Eye Examinations

For members 20 years old and younger, the IHCP reimburses for one routine vision care examination and refraction per 12-month period. For members 21 years old and older, the IHCP reimburses for one routine vision care examination and refraction every two years. If medical necessity dictates more frequent examination or care, documentation of such medical necessity must be maintained in the provider's office.

When billing eye examinations, providers should use the CPT code that best describes the examination. 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.

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

The CPT codes for eye examinations, including counseling and coordination, are as follows:

- 92002
- 92004
- 92012
- 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

Diagnostic Services

See the *Medical Policy Manual* and *405 IAC 5-23-3* for a list of services that can be provided, if medically necessary, in addition to the initial eye examination.

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.

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. The medical record must be maintained to support medical necessity and the following criteria must be met:

- 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 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** in the medical record by the supervising optometrist or physician.

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), providers should follow the guidelines in the *Third Party Liability* module.

Eyeglasses

The IHCP provides eyeglasses (including replacement eyeglasses) only when the following medical necessity guidelines are met:

- A minimum initial prescription of (or, for a subsequent pair of glasses, a minimum change of) 0.75 diopters in at least one eye for members 6 to 42 years old
- A minimum initial prescription (or, for a subsequent pair of glasses, a minimum change of) 0.50 diopters in at least one eye for members more than 42 years old
- An axis change of at least 15 degrees

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

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

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. Noncovered services include:

- Lenses with decorative designs
- Lenses larger than size 61 millimeters, except when medical necessity is documented
- Fashion tints, gradient tints, sunglasses, or 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.

According to *Indiana Administrative Code 405 IAC 5-23-4 (2)*, the IHCP may reimburse only 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
- V2745 U2 – Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens; glass, rose 1 or 2

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 and if a separate procedure code for the service exists.

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, which 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.

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
- Frames for a member with an allergy to standard frame materials
- Frames for an infant or child requiring the prescription of special-size frames that are unavailable for $20 or less

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 up to 75% of the MSRP or up to 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.

Replacement or Repair of Eyeglasses

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

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

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 bill for this service using modifier **SC –** *Medically necessary service or supply*.

In all other cases where a member requires repair or replacement of glasses before the established frequency limitations, the IHCP provides reimbursement only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the member's control, such as fire, theft, or automobile accident. Repair or replacement covers the part of the eyeglasses that is broken or damaged. Members are not entitled to a new pair of eyeglasses if the lenses or frames can be repaired or replaced.

- To bill for repair of eyeglasses, providers must use the **U8** modifier along with the appropriate procedure code for the repair.
- 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. 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.

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.*

Use of either the SC or U8 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.

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 necessity for contact lenses include, but are not limited to, members with severe facial deformity who are physically unable to wear eyeglasses and members who have severe allergies 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. Providers can bill for this service using the appropriate CPT code (92310 through 92317). These codes also include fitting contact lenses, instruction and training of the wearer, and incidental revision of the lenses during the training period; these services should not be billed separately. Providers should report follow-up of successfully fitted extended wear lenses as part of the general ophthalmological service. If, after the successful fitting of extended-wear lenses, later modification or replacement is required, providers may bill these services using 92325 or 92326.

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. Claims for this item must be submitted on the professional claim (*CMS-1500* claim form or electronic equivalent). A copy of the invoice from the eye bank or organ procurement organization showing the actual cost of acquiring the tissue must be submitted as an attachment to the claim. Providers submitting the claim on the Portal may upload the attachment electronically; providers submitting the claim as an 837 transaction must send the attachment by mail, as described in the *Claim Submission and Processing* module. 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. Effective April 7, 2017, the IHCP covers HCPCS code C1780 – *Lens, intraocular (new technology)*. Providers must submit an MSRP or cost invoice with procedure code C1780.

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 durable medical equipment (DME) National Provider Identifier (NPI).

Intraocular Stents

The IHCP covers intraocular stents inserted in conjunction with cataract surgery. See *Vision Services Codes* on the *Code Sets* page at indianamedicaid.com for covered intraocular stent codes.

If more than one stent is required in the same eye, CPT code 0376T should be used for any additional stent. All intraocular stent codes must be billed with cataract surgery CPT codes 66982, 66983, 66984, or 66985.

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 preservative-free triamcinolone acetonide 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.

Retisert

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), which providers can access through any of the following methods:

- Provider Healthcare Portal at indianamedicaid.com
- Interactive Voice Response (IVR) system at 1-800-457-4584
- 270/271 electronic data interchange (EDI) transaction

For more information on the EVS options, see the *Provider Healthcare Portal*, *Interactive Voice Response System*, and *Electronic Data Interchange* modules.

Note:	*Benefit limit information provided through the EVS and the Written Correspondence Unit is for fee-for-service (FFS) claims only. 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, such as the dates the limits were used. 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 for FFS claims. Providers should allow up to four business days for a response (plus delivery time, for inquires 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 contact the provider for additional information if needed. 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:

DXC 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.