Vision Benefit Limitations & Authorization Guide

Note: Members with Share of Cost (SOC) must meet SOC for for claims to be eligible for reimbursement.

Covered Providers: Optometrists, Ophthalmologists, Opticians, & Ocularists

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	NO		Should not be billed with eye examination codes (CPT codes 92004, 92012 and 92014) by the same provider, for the same recipient and date of service. Reimbursement for duplicate services will be reduced or denied.
Diagnostic & Ancillary Procedures	92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits	NO - Requires ICD 10 CM code	E10.10 thru E13.9, H53.10 thru H53.15, H53.19, H53.40 thru H53.489, H57.10 thru H57.8, O24.011 thru O24.93, P70.2, R51, R73.01 thru R73.9, T37.2X5A thru T37.2X5S, Z09	Covered once every 2 years. Tonometry services are included in an eye examination and should not be billed as a separate procedure. Note: This is a one-time measurement and not serial tonometry (CPT code 92100). A second eye examination with refraction within 24 months is covered only when a sign or symptom indicates a need for this service. Should not be billed with eye examination codes (CPT codes 92002, 92012, 92014) by the same provider, for the same recipient on the same date of service. Reimbursement for duplicate services will be reduced or denied. Can be rendered by an Optometrist or an Ophthalmologist.
Diagnostic & Ancillary Procedures	92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	NO		Should not be billed with eye examination codes (CPT codes 92002, 92004, and 92014) by the same provider, for the same recipient and date of service. Reimbursement for duplicate services will be reduced or denied.
Diagnostic & Ancillary Procedures	92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits	NO - Requires ICD 10 CM code	E10.10 thru E13.9, H53.10 thru H53.15, H53.19, H53.40 thru H53.489, H57.10 thru H57.8, O24.011 thru O24.93, P70.2, R51, R73.01 thru R73.9, T37.2X5A thru T37.2X5S, Z09	Covered once every 2 years. Tonometry services are included in an eye examination and should not be billed as a separate procedure. Note: This is a one-time measurement and not serial tonometry (CPT code 92100). A second eye examination with refraction within 24 months is covered only when a sign or symptom indicates a need for this service. Should not be billed with eye examination codes (CPT codes 92002, 92004, 92012 by the same provider, for the same recipient on the same date of service. Reimbursement for duplicate services will be reduced or denied. Can be rendered by an Optometrist or an Ophthalmologist.
Diagnostic & Ancillary Procedures	92015	Determination of refractive state	NO		When performed, determination of refractive state (CPT code 92015) must be separately reported when billed in conjunction with CPT code 92004 or 92014.Code 92015 is considered typical postoperative follow-up care included in the surgical package for cataract extraction surgeries. Therefore, this service is not reimbursable when billed in conjunction with or within the 90-day post follow-up period of CPT codes 66840, 66850, 66852, 66920, 66930, 66940 and 66982 thru 66985.
Diagnostic & Ancillary Procedures	92020	Gonioscopy (separate procedure)	NO - Requires ICD 10 CM code	D86.83, D86.9, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E13.311 thru E13.39, H18.051 thru H18.059, H20.00 thru H21.569, H21.81 thru H22, H25.10 thru H25.13, H26.491 thru H26.499, H27.00 thru H27.03, H31.401 thru H31.429, H34.10 thru H34.13, H34.8110 thru H34.8192, H34.8310 thru H34.8392, H34.9, H35.031 thru H35.039, H35.051 thru H35.059, H35.20 thru H35.23, H35.82, H40.001 thru H42, H44.601 thru H44.639, H44.691 thru H44.699, H44.701 thru H44.739, H44.791 thru H44.799, H47.231 thru H47.239, Q13.0 thru Q13.9, Q15.0, S05.10XA thru S05.12XS, T85.79XA thru T85.79XS, T86.842, Z96.1	

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	92025	Computerized corneal topography	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)		Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made. Computerized corneal topography (CPT code 92025) is reimbursable to optometrists within their scope of practice. It requires medical review. When billing for code 92025, providers must document in the Additional Claim Information field (Box 19) of the claim or on an attachment that the service was performed according to one of the following criteria: · Pre- or post-operatively for corneal transplant (codes 65710, 65730, 65750, 65755 and 65756) · Pre- or post-operatively prior to cataract surgery due to irregular corneal curvature or irregular astigmatism · In the treatment of irregular astigmatism as a result of corneal disease or trauma · To assist in the fitting of contact lenses for patients with corneal disease or trauma (ICD-10-CM diagnosis codes H17.00 thru H18.9) · To assist in defining further treatment This procedure is not covered under the following conditions: · When performed pre- or post-operatively for non-CMSP covered refractive surgery procedures such as codes 65760 (kerato mileusis), 65765 (keratophakia), 65767 (epikeratoplasty), 65771 (radial keratotomy), 65772 (corneal relaxing incision) and 65775 (corneal wedge resection) · When performed for routine screening purposes in the absence of associated signs, symptoms, illness or injury. When billing CPT code 92025, providers must follow split-billing procedures. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. Note: Do not bill modifier 99 with split-billable codes. The claim will be denied.
Diagnostic & Ancillary Procedures	92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes Column)	H49.00 thru H49.43, H49.88 thru H51.9, H53.001 thru H53.039, H53.121 thru H53.129, H53.15, H53.19, H53.2 thru H53.34, H55.00, H55.01	Claim should include documentation specifying medical necessity for this procedure.
Diagnostic & Ancillary Procedures	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)	NO - Requires ICD 10 CM code	A15.7, A18.50 thru A18.59, A50.00 thru A50.49, A52.15, A52.19, B00.50, B00.51, B00.59, B01.0 thru B01.89, B02.30 thru B02.39, B06.81, B06.89, B20, B37.89, B39.4, B39.5, B39.9, B46.9, C43.10 thru C43.12, D03.10 thru D03.12, C69.20 thru C69.32, C69.40 thru C69.42, C69.60 thru C69.62, C69.80 thru C69.82, C71.0 thru C71.9, C75.1, C75.2, D18.09, D31.20 thru D31.32, D33.0 thru D33.3, D35.2, D35.3, D43.3, D43.8, D43.9, D44.3, D44.4, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E11.40, E13.311 thru E13.39, F44.4, F44.6, G35, G37.0, G37.5, G43.001 thru G43.919, G45.0 thru G46.2, H02.30 thru H02.439, H02.831 thru H02.839, H21.00 thru H21.03, H30.891 thru H30.93, H32, H33.001 thru H33.059, H33.101 thru H33.199, H35.381 thru H35.389, H35.50,H40.001 thru H42, H44.20 thru H44.2E9, H46.0 thru H47.9, H53.10, H53.16 thru H53.19, H53.40 thru H53.489, H53.60 thru H53.69, H54.7, H54.8, H57.10 thru H57.13, I63.031 thru I63.239, I66.01 thru I66.9, I67.2, I67.81 thru I67.89, M31.6, Q14.1, Q15.9, S05.10 thru S05.12XS, T37.2X5A thru T37.2X5S, T37.8X5A thru T37.8X5S, Z09, Z79.899	

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Diagnostic & Ancillary Procedures	92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least two isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	NO - Requires ICD 10 CM code	A15.7, A18.50 thru A18.59, A50.00 thru A50.49, A52.15, A52.19, B00.50, B00.51, B00.59, B01.0 thru B01.89, B02.30 thru B02.39, B06.81, B06.89, B20, B37.89, B39.4, B39.5, B39.9, B46.9, C43.10 thru C43.12, D03.10 thru D03.12, C69.20 thru C69.32, C69.40 thru C69.42, C69.60 thru C69.62, C69.80 thru C69.82, C71.0 thru C71.9, C75.1, C75.2, D18.09, D31.20 thru D31.32, D33.0 thru D33.3, D35.2, D35.3, D43.3, D43.8, D43.9, D44.3, D44.4, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E11.40, E13.311 thru E13.39, F44.4, F44.6, G35, G37.0, G37.5, G43.001 thru G43.919, G45.0 thru G46.2, H02.30 thru H02.439, H02.831 thru H02.839, H21.00 thru H21.03, H30.891 thru H30.93, H32, H33.001 thru H33.059, H33.101 thru H33.199, H35.381 thru H35.389, H35.50, H40.001 thru H42, H44.20 thru H44.2E9, H46.0 thru H47.9, H53.10, H53.16 thru H53.19, H53.40 thru H53.489, H53.60 thru H53.69, H54.7, H54.8, H57.10 thru H57.13, I63.031 thru I63.239, I66.01 thru I66.9, I67.2, I67.81 thru I67.89, M31.6, Q14.1, Q15.9, S05.10 thru S05.12XS, T37.2X5A thru T37.2X5S, T37.8X5A thru T37.8X5S, Z09, Z79.899	
Diagnostic & Ancillary Procedures	92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least three isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30- 2, 24-2, or 30/60-2)	NO - Requires ICD 10 CM code	A15.7, A18.50 thru A18.59, A50.00 thru A50.49, A52.15, A52.19, B00.50, B00.51, B00.59, B01.0 thru B01.89, B02.30 thru B02.39, B06.81, B06.89, B20, B37.89, B39.4, B39.5, B39.9, B46.9, C43.10 thru C43.12, D03.10 thru D03.12, C69.20 thru C69.32, C69.40 thru C69.42, C69.60 thru C69.62, C69.80 thru C69.82, C71.0 thru C71.9, C75.1, C75.2, D18.09, D31.20 thru D31.32, D33.0 thru D33.3, D35.2, D35.3, D43.3, D43.8, D43.9, D44.3, D44.4, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E11.40, E13.311 thru E13.39, F44.4, F44.6, G35, G37.0, G37.5, G43.001 thru G43.919, G45.0 thru G46.2, H02.30 thru H02.439, H02.831 thru H02.839, H21.00 thru H21.03, H30.891 thru H30.93, H32, H33.001 thru H33.059, H33.101 thru H33.199, H35.381 thru H35.389, H35.50, H40.001 thru H42, H44.20 thru H44.2E9, H46.0 thru H47.9, H53.10, H53.16 thru H53.19, H53.40 thru H53.489, H53.60 thru H53.69, H54.7, H54.8, H57.10 thru H57.13, I63.031 thru I63.239, I66.01 thru I66.9, I67.2, I67.81 thru I67.89, M31.6, Q14.1, Q15.9, S05.10 thru S05.12XS, T37.2X5A thru T37.2X5S, T37.8X5A thru T37.8X5S, Z09, Z79.899	

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	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 - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)	H40.001 thru H40.019, H40.031 thru H40.039, H40.051 thru H40.059, H40.10X0 thru H40.239, H40.30X0 thru H40.63X4, H40.89, Q15.0	Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made. Serial tonometry (CPT code 92100) is indicated for the following conditions: · To guide treatment during the course of acute care for symptomatic or potentially dangerous elevations of intraocular pressure, for example, acute angle-closure glaucoma · When used to assess diurnal variations of intraocular pressure in the evaluation of established glaucoma · To establish or exclude glaucoma in patients with optic nerve damage or other signs/symptoms of glaucoma without documented elevation of intraocular pressure The following documentation must be included with claims for CPT code 92100: · Intraocular pressure measurements (in mmhg) for either eye, measured at a minimum of three different times during the day, and the times the measurements were performed Note: CPT code 92100 is a covered service only if performed serially (not as a one-time measurement, which would be included in the general comprehensive eye examination service). A one-time measurement of intraocular pressure is not separately reimbursable. Reasons for denial: · When services are not medically necessary and reasonable · When performed as a screening process · Measurements of intraocular pressure by one or more methods during the course of an Evaluation and Management (E&M) service are included in the allowance for the E&M code, and are not separately reimbursable as code 92100 · Confirmatory measurement of a particular finding with the same or different tonometers, or with different personnel, does not constitute serial tonometry
Diagnostic & Ancillary Procedures	92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	NO - Requires ICD 10 CM code	C69.10 thru C69.12, C69.40 thru C69.42, D31.10 thru D31.12, D31.40 thru D31.42, H16.031 thru H16.039, H16.061 thru H16.079, H17.10 thru H17.13, H18.711 thru H18.739, H21.211 thru H21.9, H22, H27.00 thru H27.03, H27.121 thru H27.129, H40.031 thru H40.039, H40.1410 thru H40.1494, H40.20X0 thru H40.53X4, H40.811 thru H40.839, H40.89, H42, T85.21XA thru T85.29XS, T85.79XA thru T85.79XS, T86.840 thru T86.842	Considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. No documentation required. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." This code is split-billable. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. Modifier 99 allowed.
Diagnostic & Ancillary Procedures	92133	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral; Optic nerve	NO - Requires ICD 10 CM code	C69.80 thru C69.82, D31.20 thru D31.22, D31.30 thru D31.32, H05.00 thru H05.9, H21.231 thru H21.239, H21.521 thru H21.529, H21.551 thru H21.559, H40.001 thru H40.63X4, H40.811 thru H40.839, H40.89, H42, H47.011 thru H47.9, H53.40 thru H53.489, Q14.2, Q15.0, S05.10XA thru S05.12XS, S06.1X0A thru S06.309S, S06.810A thru S06.829S, S06.890A thru S06.9X9S	Considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. No documentation required. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." This code is split-billable. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. Modifier 99 allowed.
Diagnostic & Ancillary Procedures	92134	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral, retina	NO - Requires ICD 10 CM code	B39.9, C69.20 thru C69.32, D31.20 thru D31.32, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E13.311 thru E13.39, H15.811 thru H15.9, H30.001 thru H31.129, H31.321 thru H31.429, H32, H33.001 thru H33.43, H34.00 thru H34.9, H35.00 thru H35.09, H35.111 thru H35.389, H35.51, H35.60 thru H35.739, H35.81 thru H35.89, H43.00 thru H43.9, H44.20 thru H44.2E9, Q14.8, S05.10XA thru S05.12XS, S06.1X0A thru S06.309S, S06.810A thru S06.829S, S06.890A thru S06.9X9ST37.2X5A thru T37.2X5S, Z79.899	Considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. No documentation required. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." This code is split-billable. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. Modifier 99 allowed.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease, with interpretation and report, unilateral or bilateral	NO - Requires ICD 10 CM code	B39.4, B39.5, B39.9, B58.01, C69.20 thru C69.42, C79.89, C79.9, D31.20 thru D31.32, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E13.311 thru E13.39, G45.3, H05.50 thru H05.53, H30.001 thru H30.93, H30.101 Thru H32, H33.011 thru H33.129, H33.191 thru H33.43, H33.8, H34.00 thru, H34.03, H34.211 thru H34.239, H34.821 thru H34.9, H35.00 thru H35.09, H35.111 thru H35.179, H35.20 thru H35.23, H35.40 thru H35.469, H35.50 thru H35.89, H36, H40.001 thru H42, H43.00 thru H43.13, H43.00 thru H43.13, H44.111 thru H44.2A9, H44.2C thru H44.2C9, H44.601 thru H44.799, Q14.1, Q14.3, Q14.8, Q14.9, S05.50XA thru S05.52XS	The following documentation regarding extended ophthalmoscopy (CPT codes 92201 and 92202) services must be maintained in the recipient's medical record: · Extended ophthalmoscopy (CPT codes 92201 and 92202) cannot bill for the patient on the same date of service. · The technique used and a drawing of the retina showing anatomy in the patient as seen at the time of the examination, including the pathology that was found Note: The slit lamp examination, including Hruby lens, hand held lens and contact lens examinations of macula, indirect, as well as direct ophthalmoscopy for fundus examination are part of the E&M service. These services are not reimbursed separately and should not be billed in addition to the E&M service. · Another diagnostic technique in addition to routine direct and indirect ophthalmoscopy is necessary and documented (for example, 360-degree scleral depression, fundus contact lens or 90-diopter lens) · Preprinted diagrams of the retina are not an acceptable alternative · A legible narrative report of the findings · Preprinted diagrams of the retina are not an acceptable alternative Considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. No documentation required. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." Allowable modifiers: U7, 22, 99.
Diagnostic & Ancillary Procedures	92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula, with interpretation and report, unilateral or bilateral	NO - Requires ICD 10 CM code	B39.4, B39.5, B39.9, B58.01, C69.20 thru C69.42, C79.89, C79.9, D31.20 thru D31.32, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E13.311 thru E13.39, G45.3, H05.50 thru H05.53, H30.001 thru H30.93, H30.101 thru H32, H33.011 thru H33.129, H33.191 thru H33.43, H33.8, H34.00 thru H34.9, H35.00 thru H35.09, H35.111 thru H35.179, H35.20 thru H35.23, H35.30 thru H35.389, H35.50 thru H35.89, H36, H40.001 thru H42, H43.00 thru H43.13, H44.2B1 thru H4.2B9, H44.2D1 thru H44.2E9, H44.601 thru H44.799, H46.00 thru H46.9, H47.011 thruh47.399, Q14.2, Q14.13, Q14.8, Q14.9, Q15.0, S05.50XA thru S05.62XS, T37.2X5A, T37.2X5D, T37.2X5S, Z79.899	The following documentation regarding extended ophthalmoscopy (CPT codes 92201 and 92202) services must be maintained in the recipient's medical record: · Extended ophthalmoscopy (CPT codes 92201 and 92202) cannot bill for the patient on the same date of service. · The technique used and a drawing of the retina showing anatomy in the patient as seen at the time of the examination, including the pathology that was found Note: The slit lamp examination, including Hruby lens, hand held lens and contact lens examinations of macula, indirect, as well as direct ophthalmoscopy for fundus examination are part of the E&M service. These services are not reimbursed separately and should not be billed in addition to the E&M service. · Another diagnostic technique in addition to routine direct and indirect ophthalmoscopy is necessary and documented (for example, 360-degree scleral depression, fundus contact lens or 90-diopter lens) · Preprinted diagrams of the retina are not an acceptable alternative · A legible narrative report of the findings. The following major criteria must be met: •Extended ophthalmoscopy is considered to be a reasonable and necessary service for evaluation of tumors of the retina and choroid (the tumor may be too peripheral for an accurate photograph), retinal tears, detachments, hemorrhages, exudative detachments and retinal defects without detachment, as well as other ocular defects. These codes are reserved for the meticulous evaluation of the eye and detailed documentation of a severe ophthalmologic problem when photography is not adequate or appropriate. •Frequency for providing these services depends upon the medical necessity in each patient and this relates to the diagnosis. A serious retinal condition must exist, or be suspected, based on routine ophthalmoscopy, which requires further detailed study. •In all instances, extended ophthalmoscopy must be medically necessary. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. It is not medically necessary, for example, to confirm information already available by other means. •A serious retinal condition is present based on ophthalmoscopy, which requires further study, such as the detailed study of pre- retinal membrane, a retinal tear detachment, a suspected retinal tear with sudden onset of symptomatic floaters or vitreous hemorrhage. Considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. No documentation required. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." Allowable modifiers: U7, 22, 99.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	NO - Requires ICD 10 CM code		Considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. No documentation required. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." Not reimbursable for the same recipient on the same date of service by any provider in conjunction with codes 92002 thru 92014, 92133, 92134, 92227, 92228, 92250 or E&M codes 99202 thru 99216, 99221 thru 99223, 99227 thru 99240, 99242 thru 99250, 99252 thru 99317, 99319 thru 99323, 99329 thru 99333, 99338, 99341, 99342, 99344 thru 99350 and 99417
Diagnostic & Ancillary Procedures	92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	NO - Requires ICD 10 CM code		Considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. No documentation required. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." Not reimbursable for the same recipient on the same date of service by any provider in conjunction with codes 92002 thru 92014, 92133, 92134, 92227, 92228, 92250 or E&M codes 99202 thru 99216, 99221 thru 99223, 99227 thru 99240, 99242 thru 99250, 99252 thru 99317, 99319 thru 99323, 99329 thru 99333, 99338, 99341, 99342, 99344 thru 99350 and 99417. This code is split-billable. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC.
Diagnostic & Ancillary Procedures	92229	Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral	NO - Requires Specified Medical Justification (See notes column)		Considered bilateral services. Therefore, a code should be billed only once and by report, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral. When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1". The allowed service is one per day, whether it is unilateral or bilateral. When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1." Provide documentation with claim specifying medical necessity.
Diagnostic & Ancillary Procedures	92250	Fundus photography with interpretation and report	NO - Requires ICD 10 CM code	B39.9, B58.01, C69.20 thru C69.32, D31.20 thru D31.32, D86.83, D86.89, D86.9, E08.311 thru E08.39, E09.311 thru E09.39, E10.311 thru E10.39, E11.311 thru E11.39, E13.311 thru E13.39, G45.3, H30.00 thru H31.429, H32, H33.011 thru H33.119, H33.191 thru H35.09, H35.171 thru H35.89, H36, H40.001 thru H42, H43.10 thru H43.13, H44.001 thru H44.009, H44.641 thru H44.659, H44.741 thru H44.759, H46.00 thru H47.539, Q15.0, S05.20XA thru S05.22XST37.2X5A Thru T37.2X5S, Z79.899	The following documentation regarding fundus photography (CPT code 92250) services must be maintained in the recipient's medical record: · Documentation indicating the condition being photographed and whether the condition is progressive or stable. · If prognosis is stable, there must be documentation stating why the procedure was medically necessary. · If prognosis is progressive, indicate the treatment and follow-up plan, and whether a referral was indicated. If additional services are warranted, a statement indicating why additional benefits are medically necessary for the patient. Note: CPT code 92250 cannot be billed in conjunction with codes 92201 or 92202 for the patient by the same provider on the same date of service.
Diagnostic & Ancillary Procedures	92284	Dark adaptation examination with interpretation and report	NO - Requires Specified Medical Justification (See notes column)		Required modifiers: TC, 26. Allowable modifiers: SA, U7, 99. Claim should include documentation specifying medical necessity for this procedure.

Note: Members with Share of Cost (SOC) must meet SOC for for claims to be eligible for reimbursement.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	NO		
Diagnostic & Ancillary Procedures	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	NO		For optometrists only.
Diagnostic & Ancillary Procedures	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection,45-59 minutes of total time is spent on the date of the encounter.	NO		
Diagnostic & Ancillary Procedures	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	NO - Requires Specified Medical Justification (See notes column)		Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.
Diagnostic & Ancillary Procedures	99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	NO		
Diagnostic & Ancillary Procedures	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the Date of the encounter.	NO		

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	NO		
Diagnostic & Ancillary Procedures	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	NO		
Diagnostic & Ancillary Procedures	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter	NO - Requires Specified Medical Justification (See notes column)		Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.
Diagnostic & Ancillary Procedures	99242	Office consultation for a new or established patient, which requires these three key components: A detailed history, A detailed examination, Medical decision making of low	NO		
Diagnostic & Ancillary Procedures	99243	Office consultation for a new or established patient, which requires these three key components: A detailed history, A detailed examination, Medical decision making of low complexity	NO		
Diagnostic & Ancillary Procedures	99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	NO - Requires Specified Medical Justification (See notes column)		Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Diagnostic & Ancillary Procedures	99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	NO - Requires Specified Medical Justification (See notes column)		Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.
Contact Lens Exam	92071	Contact lens fitting for treatment of ocular surface disease	YES	B60.13, H16.101 thru H16.399, H16.8, H16.9, H18.10 thru H18.239, H18.40 thru H18.59, H18.831 thru H18.839, S05.00XA thru S05.02XS	For recipients that fall into one of the exempt categories, claims for contact lenses and associated services are only reimbursable with authorization for the following conditions: · Aphakia · Anisometropia with aniseikonia · Corneal pathology or deformity (other than corneal astigmatism) · Corneal transplants · Keratoconus · Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the patient. · Necessary because chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses. Note: Corneal astigmatism is not considered a deformity that justifies CMSP's coverage of contact lenses. Auth must include: · Valid diagnosis or condition that precludes the satisfactory wearing of conventional eyeglasses, including documentation of clinical data when possible · Best corrected visual acuities through eyeglasses and contact lenses · Identification of the contact lens to be used by trade or manufacturer's name, base curve, diameter and power · For a diagnosis of aniseikonia (ICD-10-CM code H52.32), a statement that indicates why eyeglasses cannot be used and supporting clinical data (Anisometropia greater than three diopters, coupled with the presence of symptoms commonly associated with aniseikonia can qualify contact lenses for authorization. Where a smaller degree of anisometropia is present, detailed justification is required.) · For conditions where contact lenses are the only option, a statement of the chronic pathology or deformity of the nose, skin or ears that precludes the wearing of conventional eyeglasses · If extended wear contact lenses are prescribed, justification of why conventional, disposable or plan replacement extended wear lenses rather than daily wear lenses are necessary. (When infirmity is a pertinent factor in the decision, a statement that demonstrates the immediate availability of someone to assist the recipient in lens insertion, centering and removal is required.) · A statement that indicates whether a recipient has worn contact lenses in the past All eye appliance items with no price on file are manually priced based on invoice or catalog page. A contact lens examination includes: • Specification of optical and physical characteristics of the contact lens (such as power, size, curvature, flexibility, gas-permeability) • Multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, initial tolerance evaluation, and other tests as necessary • Instruction and training of the wearer and incidental revision of the lens during the training period • Follow-up care for six months Must bill modifier SC (medically necessary) or 22 (increased procedural services).

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Contact Lens Exam	92072	Fitting contacts for management of keratoconus, initial fitting	YES	H18.601 thru H18.629	For recipients that fall into one of the exempt categories, claims for contact lenses and associated services are only reimbursable with authorization for the following conditions: · Aphakia · Anisometropia with aniseikonia · Corneal pathology or deformity (other than corneal astigmatism) · Corneal transplants · Keratoconus · Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the patient. · Necessary because chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses. Note: Corneal astigmatism is not considered a deformity that justifies CMSP's coverage of contact lenses. Auth must include: · Valid diagnosis or condition that precludes the satisfactory wearing of conventional eyeglasses, including documentation of clinical data when possible · Best corrected visual acuities through eyeglasses and contact lenses · Identification of the contact lens to be used by trade or manufacturer's name, base curve, diameter and power · For a diagnosis of aniseikonia (ICD-10-CM code H52.32), a statement that indicates why eyeglasses cannot be used and supporting clinical data (Anisometropia greater than three diopters, coupled with the presence of symptoms commonly associated with aniseikonia can qualify contact lenses for authorization. Where a smaller degree of anisometropia is present, detailed justification is required.) · For conditions where contact lenses are the only option, a statement of the chronic pathology or deformity of the nose, skin or ears that precludes the wearing of conventional eyeglasses · If extended wear contact lenses are prescribed, justification of why conventional, disposable or plan replacement extended wear lenses rather than daily wear lenses are necessary. (When infirmity is a pertinent factor in the decision, a statement that demonstrates the immediate availability of someone to assist the recipient in lens insertion, centering and removal is required.) · A statement that indicates whether a recipient has worn contact lenses in the past All eye appliance items with no price on file are manually priced based on invoice or catalog page. A contact lens examination includes: • Specification of optical and physical characteristics of the contact lens (such as power, size, curvature, flexibility, gas-permeability) • Multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, initial tolerance evaluation, and other tests as necessary • Instruction and training of the wearer and incidental revision of the lens during the training period • Follow-up care for six months Must bill modifier SC (medically necessary) or 22 (increased procedural services).
Eye Appliance - single vision glass or plastic	V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more

Note: Members with Share of Cost (SOC) must meet SOC for for claims to be eligible for reimbursement.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - single vision glass or plastic	V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2108	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - single vision glass or plastic	V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2114	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2115	Lenticular, (myodisc), per lens, single vision	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2121	Lenticular lens, per lens, single	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2199	Not otherwise classified; single vision lens	YES and requires a manufacturer invoice		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
Eye Appliance - single vision glass or plastic	V2410	Variable asphericity lens, single vision, full field, glass or plastic, per lens	NO		Single vision lenses must meet the criteria of least one of the following prescription requirements: · Power in at least one meridian of either lens of 0.75 diopters or more · Astigmatic correction of either eye of 0.75 diopters or more · Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian · Total differential prismatic correction of 1.5 or more prism diopters in the horizontal meridian · Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Trifocal lens glass or plastic	V2300	Sphere, trifocal, plano to plus or minus 4.00d, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2303	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2304	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2305	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2306	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Trifocal lens glass or plastic	V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance – Trifocal lens glass or plastic	V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance – Trifocal lens glass or plastic	V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance – Trifocal lens glass or plastic	V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance - Trifocal lens glass or plastic	V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance – Trifocal lens glass or plastic	V2315	Lenticular, (myodisc), per lens, trifocal	NO		By report code. Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance – Trifocal lens glass or plastic	V2320	Trifocal add over 3.25d	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.
Eye Appliance – Trifocal lens glass or plastic	V2321	Lenticular lens, per lens, trifocal	NO		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer. Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance -Trifocal lens glass or plastic	V2399	Specialty trifocal	YES and requires a manufacturer invoice		Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer.
Eye Appliance - Corneal Lens	S0500	Disposable contact lens, per lens	YES and requires a manufacturer invoice		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Contact lenses billed with S0500 require an invoice or catalog page with claim for manual pricing.
Eye Appliance - Corneal Lens	S0512	Daily wear specialty contact lens, per lens	YES and requires a manufacturer invoice		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Contact lenses billed with S0512 require an invoice or catalog page with claim for manual pricing.
Eye Appliance - Corneal Lens	S0514	Color contact lens, per lens	YES and requires a manufacturer invoice		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Contact lenses billed with S0514 require an invoice or catalog page with claim for manual pricing.
Eye Appliance -Corneal Lens	V2500	Contact lens, PMMA, spherical, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Since the contact lens specifications are known and instruction and training of the wearer are not required, reimbursement rates for contact lenses billed with HCPCS codes V2500, V2510, V2511, V2513, V2520, V2521 and V2523 and modifier RA are reduced compared to contact lenses billed with modifier NU.
Eye Appliance - Corneal Lens	V2501	Contact lens, PMMA, toric or prism Ballast, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA.
Eye Appliance -Corneal Lens	V2510	Contact lens, gas permeable, spherical, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Since the contact lens specifications are known and instruction and training of the wearer are not required, reimbursement rates for contact lenses billed with HCPCS codes V2500, V2510, V2511, V2513, V2520, V2521, and V2523 and modifier RA are reduced compared to contact lenses billed with modifier NU.
Eye Appliance -Corneal Lens	V2511	Contact lens, gas permeable, toric or prism ballast, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Since the contact lens specifications are known and instruction and training of the wearer are not required, reimbursement rates for contact lenses billed with HCPCS codes V2500, V2510, V2511, V2513, V2520, V252, and V2523 and modifier RA are reduced compared to contact lenses billed with modifier NU.
Eye Appliance -Corneal Lens	V2513	Contact lens, gas permeable, extended wear, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Since the contact lens specifications are known and instruction and training of the wearer are not required, reimbursement rates for contact lenses billed with HCPCS codes V2500, V2510, V2511, V2513, V2520, V2521 and V2523 and modifier RA are reduced compared to contact lenses billed with modifier NU.
Eye Appliance -Corneal Lens	V2520	Contact lens, hydrophilic, spherical, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Since the contact lens specifications are known and instruction and training of the wearer are not required, reimbursement rates for contact lenses billed with HCPCS codes V2500, V2510, V2511, V2513, V2520, V2521 and V2523 and modifier RA are reduced compared to contact lenses billed with modifier NU.
Eye Appliance -Corneal Lens	V2521	Contact lens, hydrophilic, toric or prism ballast, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Since the contact lens specifications are known and instruction and training of the wearer are not required, reimbursement rates for contact lenses billed with HCPCS codes V2500, V2510, V2511, V2513, V2520, V2521 and V2523 and modifier RA are reduced compared to contact lenses billed with modifier NU.

Note: Members with Share of Cost (SOC) must meet SOC for for claims to be eligible for reimbursement.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Corneal Lens	V2523	Contact lens, hydrophilic, extended wear, per lens	YES		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Since the contact lens specifications are known and instruction and training of the wearer are not required, reimbursement rates for contact lenses billed with HCPCS codes V2500, V2510, V2511, V2513, V2520, V2521 and V2523 and modifier RA are reduced compared to contact lenses billed with modifier NU.
Eye Appliance - Corneal Lens	V2531	Contact lens, scleral, gas permeable, per lens	YES and requires a manufacturer invoice		Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Must bill with modifier NU or RA. Contact lenses billed with V2531 require an invoice or catalog page with claim for manual pricing.
Eye Appliance - Corneal Lens	V2599	Contact lens, other type (use only for the billing of bandage contact lenses)	YES	H02.001 thru H02.009, H02.051 thru H02.059, H16.101 thru H16.109, H16.121 thru H16.149, H16.211 thru H16.219, H16.231 thru H16.239, H16.8, H16.9, H18.10 thru H18.20, H18.221 thru H18.239, H18.421 thru H18.429, H18.451 thru H18.459, H18.50 thru H18.59, H18.831 thru H18.839, S05.00XA thru S05.02XS	Per Lens. Max number of units allowed per code is 2 regardless of whether single contact lens or multi pack is requested per eye. Bandage contact lenses may be fitted only as prescribed by a physician or a Therapeutic Pharmaceutical Agent (TPA)-certified optometrist. When billing for bandage contact lenses, providers are required to use HCPCS code V2599 (contact lens, other type) with modifier LT or RT and a valid ICD-10-CM diagnosis code on the CMS-1500 claim form for reimbursement. Unlike conventional contact lenses, bandage contact lenses do not require authorization. Note: When billing HCPCS code V2599 with both modifiers LT and RT, separate claim lines must be used for each procedure code/modifier combination to ensure accurate payment.
Eye Appliance - Prosthetic Eyes	V2623	Prosthetic eye, plastic, custom, recipient ages 18 and over	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes. Must be billed with modifier NU (new equipment) or RA (replacement/repair) for payment. The following services are included in global fee for V2623: · Evaluation and impression of the ophthalmic socket · Development of a fitting model or pattern (in acrylic plastic or wax) · Painting the iris and sclerotic colorings to replicate the anatomical characteristic of the fellow eye · Finishing · Delivery of the competed prosthesis · Six months follow-up care The following must be included for Auth approval: · A written prescription by a physician or optometrist in the medical record · An explanation of the need for the prosthetic eye · Prior prosthetic eye history · Description and justification other than a pre-cast prosthesis For replacement of a prosthetic eye, one of the following justifications must be included: · To accommodate changes resulting from orbital development in persons under 18 years of age · When necessary to prevent a significant disability · When prior prosthesis was lost or destroyed due to circumstances beyond the recipient's control · When the prior prosthesis can no longer be rehabilitated
Eye Appliance - Prosthetic Eyes	V2624	Polishing/resurfacing of ocular prosthesis	NO - See notes column for limitations		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes. Must be billed with modifier SC (Medically necessary service or supply) for payment. 2 paid claims per 12-month period for same recipient and same provider are allowed without auth. Additional services within same 12-month period requires auth and medical documentation justifying additional benefits.
Eye Appliance - Prosthetic Eyes	V2625	Enlargement of ocular prosthesis, recipient ages 11 and over	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes. Must be billed with modifier SC (Medically necessary service or supply) for payment. Must include justification for why this service is medically indicated for auth approval. If there is one paid claim in history, justification for a second claim in a 12-month period must include one of the following conditions that supports medical necessity on the auth: · Socket growth or contracture · Lagophthalmos · Ptosis · Lower lid laxity · Entropion · Ectropion · Implant exposure and other conditions can often be improved or minimized with the appropriate prosthetic modifications.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Prosthetic Eyes	V2626	Reduction of ocular prosthesis, recipient ages 11 and over	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes. Must be billed with modifier SC (Medically necessary service or supply) for payment. Must include justification for why this service is medically indicated for auth approval. If there is one paid claim in history, justification for a second claim in a 12-month period must include one of the following conditions that supports medical necessity on the auth: · Socket growth or contracture · Lagophthalmos · Ptosis · Lower lid laxity · Entropion · Ectropion · Implant exposure and other conditions can often be improved or minimized with the appropriate prosthetic modifications
Eye Appliance - Prosthetic Eyes	V2627	Scleral cover shell, recipient ages 10 and over	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes. Must be billed with modifier NU (new equipment) or RA (replacement/repair) for payment. The following services are included in global fee for V2627: · Evaluation and impression of the globe · Development of a fitting model or pattern (usually in acrylic plastic) · Painting the iris and sclerotic colorings to replicate the anatomical characteristics of the fellow eye · Finishing · Delivery of the completed prosthesis · Six months follow-up care The following must be included for Auth approval: · A written prescription by a physician or optometrist in the medical record · An explanation of the need for the prosthetic eye · Prior prosthetic eye history · Description and justification other than a pre-cast prosthesis For replacement of sclera cover shell, one of the following justifications must be included: · To accommodate changes resulting from orbital development in persons under 18 years of age · When necessary to prevent a significant disability · When prior prosthesis was lost or destroyed due to circumstances beyond the recipient's control · When the prior prosthesis can no longer be rehabilitated
Eye Appliance - Prosthetic Eyes	V2628	Fabrication and fitting of ocular conformer recipient ages 11 and over	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes. Must be billed with modifier NU (new equipment) or RA (replacement/repair) for payment. The following must be included for Auth approval: · A written prescription by a physician or optometrist in the medical record. · Justification for why this service is medically indicated. · Documentation of post-surgical use to prevent closure and/or adhesions between the orbit and eyelid during the healing process.
Eye Appliance - Prosthetic Eyes	V2629	Prosthetic eye, other type; When billed for refitting	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes. Must be billed with modifier NU (new equipment) or RA (replacement/repair) for payment. V2629 used to bill refitting of prosthetic eyes. Service requires auth. The following must be included for Auth approval: · A description of prosthetic eye services not covered by codes V2623 – V2628. · Justification for why this service is medically indicated. · For payment, a copy of the Adjudication Response and/or an attachment indicating the description of the service being billed as in either "Re-fitting" or "Transparent Sclera Shell" must be included with the claim.
Eye Appliance - Prosthetic Eyes	V2629	Prosthetic eye, other type; When billed for transparent sclera shell	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes.
Eye Appliance - Prosthetic Eyes	V2629	Prosthetic eye, other type; When billed for all other services	YES		A written prescription by a physician or optometrist is required for the provision of prosthetic eyes.
Eye Appliance - Misc Lens Items	V2702	Deluxe lens feature	YES and requires a manufacturer invoice		

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Misc Lens Items	V2710	Slab off prism, glass or plastic, per lens	YES	H52.31, H52.32	
Eye Appliance - Misc Lens Items	V2715	Prism, per lens	YES		
Eye Appliance - Misc Lens Items	V2744	Tint, photochromatic, per lens	YES	B00.50 thru B00.59, B39.4, B39.5, B39.9, C43.10 thru C43.12, C44.101, C44.191 thru C44.1922, C69.40 thru C69.92, D04.10 thru D04.12, D22.10 thru D22.12, D23.10 thru D23.12, D31.90 thru D31.92, D86.83, D86.9, E05.00, E08.311 thru E08.39, E09.311 thru E09.39, E10.10 thru E13.9, E70.20 thru E70.9, F84.0, G20, G21.11 thru G21.9, G35, G40.00 thru G40.919, G43.001 thru G43.919, G45.3, H01.001 thru H01.029, H02.001 thru H02.239, H04.121 thru H04.129, H11.001 thru H11.069, H11.151 thru H11.159, H15.001 thru H15.9, H16.001 thru H18.9, H21.331 thru H21.339, H20.00 thru H22, H25.011 thru H28, H30.001 thru H31.129, H31.301 thru H31.429, H32, H33.001 thru H35.739, H40.001 thru H40.9, H42, H43.00 thru H43.9, H44.001 thru H44.9, H46.00 thru H47.9, H52.521 thru H53.489, H54.0X33 thru H54.40, H54.50, H54.60 thru H54.8, H55.00 thru H55.89, H57.00 thru H57.9, M32.0 thru M32.9, Q12.0 thru Q13.2, Q15.0, Q85.8, Q85.9, Q90.0 thru Q90.9, S00.10XA thru S00.279XS, S05.00XA thru S05.32XS, S05.50XA thru S05.62XS, S05.8X1A thru S05.8X9S, S05.90XA thru S05.92XS, Z79.891, Z79.899, Z96.1	
Eye Appliance - Misc Lens Items	V2745	Addition to lens, tint, any color, solid, gradient, or equal, excludes photochromatic, any lens material, per lens	YES	B00.50 thru B00.59, B39.4, B39.5, B39.9, C43.10 thru C43.12, C44.101, C44.191 thru C44.1922, C69.40 thru C69.92, D04.10 thru D04.12, D22.10 thru D22.12, D23.10 thru D23.12, D31.90 thru D31.92, D86.83, D86.9, E05.00, E08.311 thru E08.39, E09.311 thru E09.39, E10.10 thru E13.9, E70.20 thru E70.9, F84.0, G20, G21.11 thru G21.9, G35, G40.00 thru G40.919, G43.001 thru G43.919, G45.3, H01.001 thru H01.029, H02.001 thru H02.239, H04.121 thru H04.129, H11.001 thru H11.069, H11.151 thru H11.159, H15.001 thru H15.9, H16.001 thru H18.9, H21.331 thru H21.339, H20.00 thru H22, H25.011 thru H28, H30.001 thru H31.129, H31.301 thru H31.429, H32, H33.001 thru H35.739, H40.001 thru H40.9, H42, H43.00 thru H43.9, H44.001 thru H44.9, H46.00 thru H47.9, H52.521 thru H53.489, H54.0X33 thru H54.40, H54.50, H54.60 thru H54.8, H55.00 thru H55.89, H57.00 thru H57.9, M32.0 thru M32.9, Q12.0 thru Q13.2, Q15.0, Q85.8, Q85.9, Q90.0 thru Q90.9, S00.10XA thru S00.279XS, S05.00XA thru S05.32XS, S05.50XA thru S05.62XS, S05.8X1A thru S05.8X9S, S05.90XA thru S05.92XS, Z79.891, Z79.899, Z96.1	

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Misc Lens Items	V2718	Press on lens, Fresnel prism, per lens	YES		
Eye Appliance - Misc Lens Items	V2750	Anti-reflective coating, per lens	YES		
Eye Appliance - Misc Lens Items	V2755	U-V Lens, per lens	YES	B00.50 thru B00.59, B39.4, B39.5, B39.9, C43.10 thru C43.12, C44.101, C44.191 thru C44.1922, C69.40 thru C69.92, D04.10 thru D04.12, D22.10 thru D22.12, D23.10 thru D23.12, D31.90 thru D31.92, D86.83, D86.9, E05.00, E08.311 thru E08.39, E09.311 thru E09.39, E10.10 thru E13.9, E70.20 thru E70.9, F84.0, G20, G21.11 thru G21.9, G35, G40.00 thru G40.919, G43.001 thru G43.919, G45.3, H01.001 thru H01.029, H02.001 thru H02.239, H04.121 thru H04.129, H11.001 thru H11.069, H11.151 thru H11.159, H15.001 thru H15.9, H16.001 thru H18.9, H21.331 thru H21.339, H20.00 thru H22, H25.011 thru H28, H30.001 thru H31.129, H31.301 thru H31.429, H32, H33.001 thru H35.739, H40.001 thru H40.9, H42, H43.00 thru H43.9, H44.001 thru H44.9, H46.00 thru H47.9, H52.521 thru H53.489, H54.0X33 thru H54.40, H54.50, H54.60 thru H54.8, H55.00 thru H55.89, H57.00 thru H57.9, M32.0 thru M32.9, Q12.0 thru Q13.2, Q15.0, Q85.8, Q85.9, Q90.0 thru Q90.9, S00.10XA thru S00.279XS, S05.00XA thru S05.32XS, S05.50XA thru S05.62XS, S05.8X1A thru S05.8X9S, S05.90XA thru S05.92XS, Z79.891, Z79.899, Z96.1	
Eye Appliance - Misc Lens Items	V2760	Scratch resistant coating, per lens	YES		
Eye Appliance - Misc Lens Items	V2761	Mirror coating, any type, solid, gradient or equal, any lens material, per lens	YES		
Eye Appliance - Misc Lens Items	V2762	Polarization, any lens material, per lens	YES		
Eye Appliance - Misc Lens Items	V2781	Progressive lens, per lens	YES and requires a manufacturer invoice		
Eye Appliance - Misc Lens Items	V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excluding polycarbonate, per lens	YES and requires a manufacturer invoice		

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Misc Lens Items	V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens	YES and requires a manufacturer invoice		
Eye Appliance - Misc Lens Items	V2784	Lens, polycarbonate or equal, any index, per lens	YES and requires a manufacturer invoice		HCPCS code V2784 (lens, polycarbonate or equal, any index, per lens) should not be billed in addition to the lens dispensing fees.
Eye Appliance - Misc. Non-Lens Items	V2499	Variable sphericity lens, other type	YES and requires a manufacturer invoice		
Eye Appliance - Misc. Non-Lens Items	V2770	Occluder lens, per lens	YES	H54.0X33 thru H54.8	
Eye Appliance - Misc. Non-Lens Items	V2799	Vision item or service, miscellaneous	YES and requires a manufacturer invoice		Use for any unlisted eye appliances. Use for specialty contact lenses that do not meet other contact lens codes or use for contact lenses whose wholesale cost is higher than CMSP's max allowable. Must bill with modifier NU or RA. Requires invoice or catalog page with claim for manual pricing. Use this code for headbands. Include the following for medical justification: · History of medical and/or physical conditions (for example, cerebral palsy, multiple sclerosis, seizures, epilepsy, autism, Down Syndrome, Attention Deficit Disorder, brain trauma, physical handicap, etc.) that hinder the continuous wearing of eyeglasses. · History of participation in physical or athletic activities. · History of wearing headbands in the past.
Eyeglass Dispensing	92340	Eyeglass dispensing, single vision, (quantity greater than two, recipient 38 years of age or older on the date of service)	NO	Primary: H52.4 Secondary: H53.10, H53.141 thru H53.149, H53.15, H53.16, H53.19, H53.8, H53.9, R48.3	Eyeglass cases and frame adjustments, alignment and straightening are included in the CMSP reimbursement for dispensing fees of ophthalmic lenses. Rate is PER lens. Dispensing fees include ordering, fitting and adjusting of eyeglasses, and follow-up services for six months after the date of service. Required modifiers: NU, RA.
Eyeglass Dispensing	92341	Eyeglass dispensing, bifocal, recipient younger than 38 years of age on the date of service	NO	Primary: H50.43, H51.12, H52.521 thru H52.539, H52.7	Eyeglass cases and frame adjustments, alignment and straightening are included in the CMSP reimbursement for dispensing fees of ophthalmic lenses. Rate is PER lens. Dispensing fees include ordering, fitting and adjusting of eyeglasses, and follow-up services for six months after the date of service. Required modifiers: NU, RA.
Eyeglass Dispensing	92342	Eyeglass dispensing, trifocal, Recipient younger than 38 years of age on the date of service	NO	Primary: H50.43, H51.12, H52.521 thru H52.539, H52.7	Rate is PER lens. Dispensing fees include ordering, fitting and adjusting of eyeglasses, and follow-up services for six months after the date of service. Eyeglass cases and frame adjustments, alignment and straightening are included in the CMSP reimbursement for dispensing fees of ophthalmic lenses. Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 thru V2321 for trifocal lenses and CPT code 92342 for the dispensing of trifocal lenses) must be billed with modifier KX in conjunction with RA, on the same claim line, to indicate that the provider has documentation. On file stating that the recipient is a current trifocal wearer and not a first-time wearer. Required modifiers: NU, RA.
Eyeglass Dispensing	92352	Eyeglass dispensing, single vision, (quantity greater than two), recipient 38 years of age or older on the date of service	NO	Primary: H52.4 Secondary: H53.10, H53.141 thru H53.149, H53.15, H53.16, H53.19, H53.8, H53.9, R48.3	Eyeglass cases and frame adjustments, alignment and straightening are included in the CMSP reimbursement for dispensing fees of ophthalmic lenses. Rate is PER lens. Dispensing fees include ordering, fitting and adjusting of eyeglasses, and follow-up services for six months after the date of service. Required modifiers: NU, RA.

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eyeglass Dispensing	92353	Eyeglass dispensing, bifocal, recipient younger than 38 years of age on the date of service	NO	Primary: H50.43, H51.12, H52.521 thru H52.539, H52.7	Eyeglass cases and frame adjustments, alignment and straightening are included in the CMSP reimbursement for dispensing fees of ophthalmic lenses. Rate is PER lens. Dispensing fees include ordering, fitting and adjusting of eyeglasses, and follow-up services for six months after the date of service. Required modifiers: NU, RA.
Eyeglass Repair	92370	Repair and refitting spectacles; except for aphakia	NO		Claims for frame repair and frame parts should be billed with either 92370 or 92371. Claims for CPT code 92370 or 92371 will be denied if billed with HCPCS code V2020 (frames, purchases) for the same recipient on the same date of service.
Eyeglass Repair	92371	Spectacle prosthesis for aphakia	NO		Claims for frame repair and frame parts should be billed with either 92370 or 92371. Claims for CPT code 92370 or 92371 will be denied if billed with HCPCS code V2020 (frames, purchases) for the same recipient on the same date of service.
Cataract Surgery	66989	Extracapsular cataract removal with Insertion of intraocular lens prosthesis	YES		Allowable modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 52, 53, 54, 55, 62, 66, 76, 77, 78, 79, 99.
Cataract Surgery	66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis	YES		Allowable modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 52, 53, 54, 55, 62, 66, 76, 77, 78, 79, 99.
Supple-Mental Procedures	65205	Removal of foreign body, external eye; conjunctival superficial	NO - Requires ICD 10 CM code	S05.90XA thru S05.90XS, T15.10XA thru T15.12XS	Assistant Surgeon services not payable.
Supple-Mental Procedures	65210	Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival or scleral nonperforating	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)	H11.111 thru H11.129, T15.10XA thru T15.12XS	Assistant Surgeon services not payable. Modifiers 22 (unusual procedural services) and 54 (surgical care only) are allowable modifiers but are not required for reimbursement. Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made. Documentation to be included: · Complaints of foreign body sensation, irritation or pain · Description of embedded foreign body removed from patient's eye · Statement of the treatment plan, including but not limited to, medications prescribed, technique used, follow-up schedule, and whether a referral was made. · If additional benefits are warranted, a statement indicating why additional benefits are medically necessary for the patient.
Supple-Mental Procedures	65220	Removal of foreign body, external eye; corneal, without slit lamp	NO - Requires ICD 10 CM code	T15.00XA thru T15.02XS	Assistant Surgeon services not payable.
Supple-Mental Procedures	65222	Removal of foreign body, external eye; corneal, with slit lamp	NO - Requires ICD 10 CM code	T15.00XA thru T15.02XS	Assistant Surgeon services not payable.
Supple-Mental Procedures	65430	Scraping of cornea, diagnostic, for smear and/or culture	NO		
Supple-Mental Procedures	65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, Curettage)	NO		
Supple-Mental Procedures	65436	Removal of corneal epithelium; with Application of chelating agent (eg, EDTA)	NO		
Supple-Mental Procedures	67820	Correction of trichiasis; epilation, by forceps only	NO - Requires ICD 10 CM code	A71.0 thru A71.9, B02.39, H02.001 thru H02.059, H02.861 thru H02.869, H02.89, H57.10 thru H57.13, L12.1, L51.0 thru L51.9, Q10.3, S05.00XA thru S05.02XS, T26.00XA thru T26.92XS	Modifiers 22 (unusual procedural services) and 54 (surgical care only) are allowable modifiers but are not required for reimbursement. Allowable modifiers: E1 thru E4, 22, 54.

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Supple-Mental Procedures	67938	Removal of embedded foreign body, eyelid	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)	H02.811 thru H02.819, H57.10 thru H57.13, S00.251A thru S00.259S, T15.10XA thru T15.82XS, T15.90XA thru T15.92XS	Modifiers 22 (unusual procedural services) and 54 (surgical care only) are allowable modifiers but are not required for reimbursement. Allowable modifiers: E1 thru E4, 22, 54 Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made. Documentation to be included: · Complaints of foreign body sensation, irritation or pain · Description of embedded foreign body removed from patient's eye · Statement of the treatment plan, including but not limited to, medications prescribed, technique used, follow-up schedule, and whether a referral was made · If additional benefits are warranted, a statement indicating why additional benefits are medically necessary for the patient
Supple-Mental Procedures	68761	Closure of the lacrimal punctum; by plug, each	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)	H02.531 thru H02.539, H04.121 thru H04.129, H04.161 thru H04.169, H16.121 thru H16.129, H16.141 thru H16.149, H16.211 thru H16.229, H16.8, H16.9, H18.831 thru H18.839, M35.00, M35.01	Use CPT code 68761 with modifier E1 thru E4 for closure of the lacrimal punctum, by permanent plug. CPT code 68761 billed with modifier SC is not reimbursable when billed with any other surgical modifier (E1 to E4) by the same provider, for the same recipient on the same date of service. Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made. Documentation to be included: Complaints from patients of one of the following symptoms: scratchy, sandy, foreign body sensation, itching, excessive mucous secretion, burning sensation, photosensitivity, redness, and pain.
Supple-Mental Procedures	68801	Dilation of lacrimal punctum, with or without irrigation	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)	H04.22 thru H04.229, H04.32 thru H04.329, H04.41 thru H04.419, H04.43 thru H04.439, H04.551 thru H04.569	Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made. Medical record documentation should indicate that before these procedures were performed an adequate lacrimal work-up and non-invasive evaluation was completed. Such an evaluation should include at minimum the following: · Consideration by history and physical examination (including slit lamp) of likely pre-punctal and/or non-obstructive causes for epiphora, such as disturbances of ocular surface tear flow by lid malposition, allergy, dry eye or blepharitis · Non-invasive testing to diagnose punctal or post-punctal obstruction and to identify the site and degree of obstruction, such as by using dye disappearance testing when appropriate · Initiation of appropriate treatment · The medical record must contain a clear procedure note, documenting the anesthesia, dilation, probing and irrigation procedures. It must indicate the results, such as the likely site(s) of obstruction and whether and to what degree patency has been confirmed/established, or persistent obstruction remains. · If additional benefits are warranted, a statement indicating why additional benefits are medically necessary for the patient.
Supple-Mental Procedures	76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)	H17.10 thru H17.13, H18.10 thru H18.13, H18.20, H18.51 thru H18.59, H21.551 thru H21.559 *, H40.001 thru H40.10X4 *,H40.1110 Thru H40.1194 *, H40.1210 thru H40.9 *, H42, Q15.0	CPT code 76514 is reimbursable only once in a lifetime when billed with the glaucoma-related diagnosis codes indicated in the above table. Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.

Note: Members with Share of Cost (SOC) must meet SOC for for claims to be eligible for reimbursement.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Supple-Mental Procedures	92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	NO - Requires Specified Medical Justification (See notes column)		For recipients that fall into one of the exempt categories, claims for contact lenses and associated services are only reimbursable with authorization for the following conditions: · Aphakia · Anisometropia with aniseikonia · Corneal pathology or deformity (other than corneal astigmatism) · Corneal transplants · Keratoconus · Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the patient. · Necessary because chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses. Note: Corneal astigmatism is not considered a deformity that justifies CMSP's coverage of contact lenses. Auth must include: · Valid diagnosis or condition that precludes the satisfactory wearing of conventional eyeglasses, including documentation of clinical data when possible · Best corrected visual acuities through eyeglasses and contact lenses · Identification of the contact lens to be used by trade or manufacturer's name, base curve, diameter and power · For a diagnosis of aniseikonia (ICD-10-CM code H52.32), a statement that indicates why eyeglasses cannot be used and supporting clinical data (Anisometropia greater than three diopters, coupled with the presence of symptoms commonly associated with aniseikonia can qualify contact lenses for authorization. Where a smaller degree of anisometropia is present, detailed justification is required.) · For conditions where contact lenses are the only option, a statement of the chronic pathology or deformity of the nose, skin or ears that precludes the wearing of conventional eyeglasses A contact lens examination includes: • Specification of optical and physical characteristics of the contact lens (such as power, size, curvature, flexibility, gas-permeability) • Multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, initial tolerance evaluation, and other tests as necessary • Instruction and training of the wearer and incidental revision of the lens during the training period • Follow-up care for six months When requesting authorization, the contact lens examination (CPT codes 92310 thru 92312) must be requested with the contact lenses (HCPCS codes S0500, S0512, S0514, V2500 thru V2523, V2531 or V2799). Must bill modifier SC (medically necessary) or 22 (increased procedural services). Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.

Note: Members with Share of Cost (SOC) must meet SOC for for claims to be eligible for reimbursement.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Supple-Mental Procedures	92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; Corneal lens for aphakia, one eye	NO - Requires Specified Medical Justification (See notes column)		For recipients that fall into one of the exempt categories, claims for contact lenses and associated services are only reimbursable with authorization for the following conditions: Aphakia Anisometropia with aniseikonia Corneal pathology or deformity (other than corneal astigmatism) Corneal transplants Keratoconus · Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the patient. · Necessary because chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses. Note: Corneal astigmatism is not considered a deformity that justifies CMSP's coverage of contact lenses. Auth must include: · Valid diagnosis or condition that precludes the satisfactory wearing of conventional eyeglasses, including documentation of clinical data when possible Best corrected visual acuities through eyeglasses and contact lenses Identification of the contact lens to be used by trade or manufacturer's name, base curve, diameter and power · For a diagnosis of aniseikonia (ICD-10-CM code H52.32), a statement that indicates why eyeglasses cannot be used and supporting clinical data (Anisometropia greater than three diopters, coupled with the presence of symptoms commonly associated with aniseikonia can qualify contact lenses for authorization. Where a smaller degree of anisometropia is present, detailed justification is required.) · For conditions where contact lenses are the only option, a statement of the chronic pathology or deformity of the nose, skin or ears that precludes the wearing of conventional eyeglasses · If extended wear contact lenses are prescribed, justification of why conventional, disposable or plan replacement extended wear lenses rather than daily wear lenses are necessary. (When infirmity is a pertinent factor in the decision, a statement that demonstrates the immediate availability of someone to assist the recipient in lens insertion, centering and removal is required.) A statement that indicates whether a recipient has worn contact lenses in the past A contact lens examination includes: • Specification of optical and physical characteristics of the contact lens (such as power, size, curvature, flexibility, gas-permeability) • Multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, initial tolerance evaluation, and other tests as necessary • Instruction and training of the wearer and incidental revision of the lens during the training period • Follow-up care for six months When requesting authorization, the contact lens examination (CPT codes 92310 thru 92312) must be requested with the contact lenses (HCPCS codes S0500, S0512, S0514, V2500 thru V2523, V2531 or V2799). Must bill modifier SC (medically necessary) or 22 (increased procedural services). Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.
Supple-Mental Procedures	92499	Unlisted ophthalmological service or procedure	NO - Requires ICD 10 CM code AND Specified Medical Justification (See notes column)	H54.0X33 thru H54.3, H54.8	The low vision examination includes the professional evaluation, fitting of the low vision aid and subsequent supervision, if appropriate, including six months of follow-up care. All claims for low vision exams require medical justification for reimbursement, including: · Beneficiary's name and date of birth · Spectacle prescription and best-corrected visual acuities (measured monocularly), where possible · Visual acuities through the low vision aid. For near point use, also state working distance. · The etiology, current status and prognosis of the visual defect · The purpose of the prescribed low vision aid in the recipient's daily living activities · Aid identification, including catalog device name/number, manufacturer/distributor and cost · Results from any additional low vision tests performed to justify a low vision exam (e.g. Contrast, glare sensitivity) · Identification of the low vision aids trialed, and which aids were prescribed. If no low vision aid was prescribed, an explanation why · 92499 is used to bill for repair of a prosthetic eye. Justification for the repair must be included with the claim for payment. This service can be billed to CMSP directly "By Report" without prior authorization.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Supple-Mental Procedures	92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; Corneal lens for aphakia, both eyes	NO - Requires Specified Medical Justification (See notes column)		For recipients that fall into one of the exempt categories, claims for contact lenses and associated services are only reimbursable with authorization for the following conditions: ·Aphakia ·Anisometropia with aniseikonia ·Corneal pathology or deformity (other than corneal astigmatism) ·Corneal transplants ·Keratoconus ·Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the patient. ·Necessary because chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses. Note: Corneal astigmatism is not considered a deformity that justifies CMSP's coverage of contact lenses. Auth must include: ·Valid diagnosis or condition that precludes the satisfactory wearing of conventional eyeglasses, including documentation of clinical data when possible Best corrected visual acuities through eyeglasses and contact lenses Identification of the contact lens to be used by trade or manufacturer's name, base curve, diameter and power ·For a diagnosis of aniseikonia (ICD-10-CM code H52.32), a statement that indicates why eyeglasses cannot be used and supporting clinical data (Anisometropia greater than three diopters, coupled with the presence of symptoms commonly associated with aniseikonia can qualify contact lenses for authorization. Where a smaller degree of anisometropia is present, detailed justification is required.) ·For conditions where contact lenses are the only option, a statement of the chronic pathology or deformity of the nose, skin or ears that precludes the wearing of conventional eyeglasses ·If extended wear contact lenses are prescribed, justification of why conventional, disposable or plan replacement extended wear lenses rather than daily wear lenses are necessary. (When infirmity is a pertinent factor in the decision, a statement that demonstrates the immediate availability of someone to assist the recipient in lens insertion, centering and removal is required.) A statement that indicates whether a recipient has worn contact lenses in the past. A contact lens examination includes: • Specification of optical and physical characteristics of the contact lens (such as power, size, curvature, flexibility, gas-permeability) • Multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, initial tolerance evaluation, and other tests as necessary • Instruction and training of the wearer and incidental revision of the lens during the training period • Follow-up care for six months When requesting authorization, the contact lens examination (CPT codes 92310 thru 92312) must be requested with the contact lenses (HCPCS codes S0500, S0512, S0514, V2500 thru V2523, V2531 or V2799). Must bill modifier SC (medically necessary) or 22 (increased procedural services). Requires medical justification which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.
Evoked Response Testing - Visual	95930	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report	NO		Bill with X4520 for visual evoked response testing.
Eye Appliance -Bifocal lens glass or plastic	V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Bifocal lens glass or plastic	V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance -Bifocal lens glass or plastic	V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.

Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Bifocal lens glass or plastic	V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2215	Lenticular (myodisc), per lens, bifocal	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2220	Bifocal add over 3.25d	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2221	Lenticular lens, per lens, bifocal	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2299	Specialty bifocal	YES and requires a manufacturer invoice		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Bifocal lens glass or plastic	V2430	Variable asphericity lens, bifocal, full field, glass or plastic, per lens	NO		Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
Eye Appliance - Frames & Frame Repair/Parts Replacement	V2020	Frames, purchases	NO	Frames (quantity two, recipient Younger than 38 years of age on the date of service): Primary: H50.43, H51.12, H52.511 Thru H52.539 or H52.7 Frames (quantity two, recipient 38 years of age or older on the date of service): Primary: H52.4 and Secondary: H53.10, H53.141 thru H53.149, H53.15, H53.16, H53.19, H53.8 or H53.9	Eyeglass cases are not separately reimbursable and are included in CMSP's maximum allowable for eyeglass frames and lenses. Frames must be billed with modifier NU or RA. Use modifier NU when supplying frames to recipients with no prior history of usage. Modifier RA is used to indicate replacement of eyeglass frames. Replacement of frames within two years of initial coverage is limited to the same model whenever feasible. Replacement of frames within two years is not covered if an existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken frame part. CMSP will not replace frames that are deliberately destroyed, abused or discarded by recipients. Signed statement must be retained by provider for at least 3 years. When frequency limits are exceeded, providers may be required to also submit the following documentation with claims for the repair or replacement of eyeglass frames: · Patient's name and date · Circumstances for repair or replacement · A statement certifying that a loss, breakage or damage was beyond the patient's control, and the steps taken to recover the lost item · Patient's signature or the signature of patient's representative or guardian · Dispensing optical providers who dispense a devise requiring a prescription or written order must maintain the following in their files to qualify for reimbursement: • CMSP recipient's printed name and signature, or · Signature of the person receiving the eye appliance, and · Relationship of the recipient to the person receiving the prescription if the recipient is not picking up the eye appliance, Date signed, Prescription number or item description of the eye appliance dispensed. Two pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists: · There is evidence that a recipient cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern.

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance -Frames & Frame Repair/Parts Replacement	S0516	Safety eyeglass frames	YES and requires a manufacturer invoice		Eyeglass cases are not separately reimbursable and are included in CMSP's maximum allowable for eyeglass frames and lenses. Requires medical justification for auth approval. Manually priced and based on wholesale price. Must include invoice or catalog page with claim. Frames must be billed with modifier NU or RA. Use modifier NU when supplying frames to recipients with no prior history of usage. Modifier RA is used to indicate replacement of eyeglass frames. Replacement of frames within two years of initial coverage is limited to the same model whenever feasible. Replacement of frames within two years is not covered if an existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken frame part. CMSP will not replace frames that are deliberately destroyed, abused or discarded by recipients. Frame replacement may be covered for reasons other than loss, theft or destruction in circumstances beyond a recipient's control. Providers must obtain from a recipient a signed statement that explains the circumstances of the replacement and the reason the existing frame cannot be used. Signed statement must be retained by provider for at least 3 years. When frequency limits are exceeded, providers may be required to also submit the following documentation with claims for the repair or replacement of eyeglass frames: · Patient's name and date · Circumstances for repair or replacement · A statement certifying that a loss, breakage or damage was beyond the patient's control, and the steps taken to recover the lost item · Patient's signature or the signature of patient's representative or guardian Dispensing optical providers who dispense a devise requiring a prescription or written order must maintain the following in their files to qualify for reimbursement: • CMSP recipient's printed name and signature, or signature of the person receiving the eye appliance, and Relationship of the recipient to the person receiving the prescription if the recipient is not picking up the eye appliance · Date signed · Prescription number or item description of the eye appliance dispensed Two pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists: • There is evidence that a recipient cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern. • A recipient currently uses two pairs of such eyeglasses and does not use multifocal eyeglasses. When billing for two pairs of single vision eyeglasses in lieu of bifocals for recipients age 38 and older, if two eyeglass frames are prescribed, providers must enter V2020 on same claim line with 2 units and include the dx code H52.4 (Presbyopia) and one of the following dx codes as secondary dx: H53.10, H53.141-H53.149, H53.15, H53.16, H53.19, H53.8, H53.9. All multifocal and nearpoint eyeglasses (in addition to the distance prescription) must be justified for recipients younger than 38 years of age on the date of service by documenting the need for eyeglasses in the medical record.

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance – Frames & Frame Repair/Parts Replacement	V2025	Deluxe frame	YES and requires a manufacturer invoice		Eyeglass cases are not separately reimbursable and are included in CMSP's maximum allowable for eyeglass frames and lenses. Requires medical justification for auth approval. Manually priced and based on wholesale price. Must include invoice or catalog page with claim. Frames must be billed with modifier NU or RA. Use modifier NU when supplying frames to recipients with no prior history of usage. Modifier RA is used to indicate replacement of eyeglass frames. Replacement of frames within two years of initial coverage is limited to the same model whenever feasible. Replacement of frames within two years is not covered if an existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken frame part. CMSP will not replace frames that are deliberately destroyed, abused or discarded by recipients. Signed statement must be retained by provider for at least 3 years. When frequency limits are exceeded, providers may be required to also submit the following documentation with claims for the repair or replacement of eyeglass frames: · Patient's name and date · Circumstances for repair or replacement · A statement certifying that a loss, breakage or damage was beyond the patient's control, and the steps taken to recover the lost item · Patient's signature or the signature of patient's representative or guardian Dispensing optical providers who dispense a devise requiring a prescription or written order must maintain the following in their files to qualify for reimbursement: • CMSP recipient's printed name and signature, or Signature of the person receiving the eye appliance, and relationship of the recipient to the person receiving the prescription if the recipient is not picking up the eye appliance, Date signed, Prescription number or item description of the eye appliance dispensed Two pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists: • There is evidence that a recipient cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern. • A recipient currently uses two pairs of such eyeglasses and does not use multifocal eyeglasses. When billing for two pairs of single vision eyeglasses in lieu of bifocals for recipients age 38 and older, if two eyeglass frames are prescribed, providers must enter V2020 on same claim line with 2 units and include the dx code H52.4 (Presbyopia) and one of the following dx codes as secondary dx: H53.10, H53.141-H53.149, H53.15, H53.16, H53.19, H53.8, H53.9. All multifocal and nearpoint eyeglasses (in addition to the distance prescription) must be justified for recipients younger than 38 years of age on the date of service by documenting the need for eyeglasses in the medical record. When billing for two pairs of single vision eyeglasses in lieu of bifocals for recipients younger than 38 years of age, if two eyeglass frames are prescribed, providers must enter HCPCS code V2020 (frames, purchases) on the same claim line with two units, document the need for the eyeglasses in the medical record and include one of the following ICD-10-CM diagnosis codes as a primary diagnosis code on the claim: H50.43, H51.12, H52.511- H52.519, H52.521-H52.529, H52.531-H52.539, H52.7
Eye Appliance -Low Vison Aids	V2600	Handheld low vision aids and other nonspectacle mounted aids	NO but requires a manufacturer invoice	H54.0X33 to H54.3, H54.8 (blindness and low vision).	When billing for multiple low vision aids, providers must use a separate claim line item for each aid. Must be billed with Modifier NU (new equipment) or RA (replacement). Modifier NU is used when supplying or dispensing low vision aids to recipients with no prior history of usage of the low vision aids. Modifier RA is used to indicate replacement of a low vision aid that has been in use for some time. Must be billed with 92499. Auth not required for low vision exam but need justification of medical necessity with claim. Can use auth for medical justification or if no auth, include the following with claim: · Beneficiary's name and date of birth · Spectacle prescription and best-corrected visual acuities (measured monocularly), where possible · Visual acuities through the low vision aid. For near point use, also state working distance. · The etiology, current status and prognosis of the visual defect · The purpose of the prescribed low vision aid in the recipient's daily living activities · Aid identification, including catalog device name/number, manufacturer/distributor and cost · Low vision exam includes professional eval, fitting of low vision aid and subsequent supervision, including 6 months of follow up care. Electronic magnification devices and devices that do not incorporate a lens for use with the eye are not CMSP benefits. Optical low vision aids are covered if: · The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point. · The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means. · The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient. · The aid prescribed or provided is the least costly type that will meet the needs of the recipient. Low vision aids with billed amounts less than $100 do not require authorization but are subject to post-service evaluation prior to reimbursement. Claims should include medical justification as listed under "Required Information" in this section. Low vision aids with billed amounts $100 or greater require authorization. A valid TAR will serve as the required medical justification.

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Type	Procedure Codes	Procedure Code Description	Auth Required?	REQUIRED DX CODE(S)	LIMITATIONS/NOTES
Eye Appliance - Low Vison Aids	V2610	Single lens spectacle mounted low vision aids	NO - but requires a manufacturer invoice	H54.0X33 to H54.3, H54.8 (blindness and low vision).	When billing for multiple low vision aids, providers must use a separate claim line item for each aid. Therefore, the maximum quantity billed for HCPCS code V2600, V2610 or V2615 is "1." Must be billed with Modifier NU (new equipment) or RA (replacement). Modifier NU is used when supplying or dispensing low vision aids to recipients with no prior history of usage of the low vision aids. Modifier RA is used to indicate replacement of a low vision aid that has been in use for some time. Must be billed with 92499. Auth not required for low vision exam but need justification of medical necessity with claim. Can use auth for medical justification or if no auth, include the following with claim: - Beneficiary's name and date of birth - Spectacle prescription and best-corrected visual acuities (measured monocularly), where possible - Visual acuities through the low vision aid. For near point use, also state working distance. - The etiology, current status and prognosis of the visual defect - The purpose of the prescribed low vision aid in the recipient's daily living activities - Aid identification, including catalog device name/number, manufacturer/distributor and cost Low vision exam includes professional eval, fitting of low vision aid and subsequent supervision, including 6 months of follow up care. Electronic magnification devices and devices that do not incorporate a lens for use with the eye are not CMSP benefits. Optical low vision aids are covered if: The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point. The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means. The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient. The aid is the least costly type. Low vision aids with billed amounts less than $100 do not require authorization but are subject to post-service evaluation prior to reimbursement. Claims should include medical justification as listed under "Required Information" in this section. Low vision aids with billed amounts $100 or greater require authorization. A valid TAR will serve as the required medical justification. Therefore, medical justification does not have to be included with these claims.
Eye Appliance - Low Vison Aids	V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system	NO - but requires a manufacturer invoice	H54.0X33 to H54.3, H54.8 (blindness and low vision).	When billing for multiple low vision aids, providers must use a separate claim line item for each aid. Therefore, the maximum quantity billed for HCPCS code V2600, V2610 or V2615 is "1." Must be billed with Modifier NU (new equipment) or RA (replacement). Modifier NU is used when supplying or dispensing low vision aids to recipients with no prior history of usage of the low vision aids. Modifier RA is used to indicate replacement of a low vision aid that has been in use for some time. Must be billed with 92499. Auth not required for low vision exam but need justification of medical necessity with claim. Can use auth for medical justification or if no auth, include the following with claim: - Beneficiary's name and date of birth. - Spectacle prescription and best-corrected visual acuities (measured monocularly), where possible. - Visual acuities through the low vision aid. For near point use, also state working distance. - The etiology, current status and prognosis of the visual defect. - The purpose of the prescribed low vision aid in the recipient's daily living activities. Low vision aids with billed amounts less than $100 do not require authorization but are subject to post-service evaluation prior to reimbursement. Claims should include medical justification as listed under "Required Information" in this section. Low vision aids with billed amounts $100 or greater require authorization. A valid TAR will serve as the required medical justification. Therefore, medical justification does not have to be included with these claims.
Evoked Response Testing - Visual	X4520	Visual Evoked Potential Response Test	NO - See limitations in notes column		Use with CPT 95930. If more than one evoked response test is performed on the same recipient for the same date of service, the second and subsequent tests will be reimbursed at a reduced amount. Must also provide medical justification if more than one evoked response test performed on same recipient for same DOS.