

Eye Appliances

This section contains general information about program coverage of eye appliances as specified in *California Code of Regulations* [CCR], Title 22, Section 51317. Refer to specific policy sections for additional information.

Notice: Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) excluded several optional benefits from coverage under the Medi-Cal program, including dispensing optician and fabricating optical laboratory services. Refer to the *Optional Benefits Exclusion* section in this manual for policy details, including information regarding exemptions to the excluded benefits. All codes listed in this section are affected by the optional benefits exclusion policy. Ocularist services are not impacted by AB X3 5 and remain reimbursable for all Medi-Cal recipients.

GENERAL INFORMATION

Program Coverage

In addition to the policy described in the *Optional Benefits Exclusion* section, eye appliances are only covered by the written prescription of a physician or optometrist, subject to the provisions outlined in the policy sections of this manual.

Covered Eye Appliances

For recipients that fall into one of the exempt categories, the following eye appliances are covered by Medi-Cal:

- Eyeglass frames that conform to the American National Standards Institute (ANSI) Requirements for Dress Ophthalmic Frames (Z80.5) and meet the requirements listed under “Program Coverage” in the *Eyeglass Frames* section of this manual
- Prescription eyeglass lenses that conform to ANSI Requirements for First Quality Prescription Lenses (Z80.1) and meet the requirements listed under “Program Coverage” in the *Eyeglass Lenses* section of this manual
- Contact lenses that conform to the federal Food and Drug Administration (FDA) approved applications for hydrophilic lenses; ANSI Requirements for First Quality Contact Lenses (Z80.2) for hard and gas permeable lenses; and meet the requirements listed under “Program Coverage” in the *Contact Lenses* section of this manual
- Low vision optical aids, excluding electronic magnification devices, that meet the requirements listed under “Program Coverage” in the *Low Vision Aids* section of this manual

- Prosthetic eyes with a written prescription by a physician or optometrist that meet the requirements listed under “Program Coverage” in the *Prosthetic Eyes* section in this manual.

Note: Prosthetic eyes are not impacted by the Optional Benefits Exclusion policy and remain covered for all eligible Medi-Cal recipients regardless of age.

Appliances Requiring Authorization

The following HCPCS codes for contact lenses and ophthalmic frames, lenses, and other miscellaneous lens items require authorization and must be billed with either modifier NU (new equipment) or RA (repair/replacement), in addition to those modifiers for recipients who meet the exemptions specified in the *Optional Benefits Exclusion* section in this manual.

Authorization requests for these eye appliances must be submitted on the 50-3 TAR form.

<u>HCPCS Code</u>	<u>Description</u>
V2025	Deluxe frame
V2199	Not otherwise classified; single vision lens
V2299	Specialty bifocal
V2399	Specialty trifocal
V2499	Variable sphericity lens, other type
V2702	Deluxe lens feature
V2750	Antireflective coating, per lens
V2760	Scratch resistant coating, per lens
V2761	Mirror coating, any type, solid, gradient or equal, any lens material, per lens
V2762	Polarization, any lens material, per lens
V2781	Progressive lens, per lens
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens
V2784 *	Lens, polycarbonate or equal, any index, per lens
V2799	Vision Service, miscellaneous

* Refer to the *Eyeglass Lenses* section of this manual for policy and billing information.

**Eye Appliance Items With
No Price on File**

All eye appliance items with no price on file are manually priced based on invoice or catalog page. Providers have a choice of whether the pricing is done at the time of TAR adjudication or at the time of claim processing.

In order to have pricing done at the time of TAR adjudication, the provider must include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at the Department of Health Care Services (DHCS) Vision Services Branch (VSB) will determine the price and assign a Pricing Indicator (PI) of 3. When this is done, the claim can be submitted without the invoice or catalog page. Providers must enter the 10-digit TCN followed by the PI of 3 (eleventh digit) in the *Prior Authorization Number* field (Box 23) of the *CMS-1500* claim form.

In order to have pricing done at the time of claim processing, the provider does not have to include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at DHCS VSB will assign a PI of 0. When this is done, the claim must be submitted with the invoice or catalog page. Providers must enter the 10-digit TCN followed by the PI of 0 (eleventh digit) in the *Prior Authorization Number* field (Box 23) of the *CMS-1500* claim form.

Note: Authorization of “By Report” procedure codes is only a determination that the appliance and associated services are medically necessary. Determination of reimbursement fees in each case will be made by Medi-Cal. If a TAR is approved, a claim associated with that TAR that fails to meet other Medi-Cal billing requirements may be denied.

**Supplemental
Eye Appliances**

In addition to the one pair of eyeglasses (single vision or bifocal) or medically necessary contact lens covered by Medi-Cal, coverage of supplemental eye appliances is limited to the following:

- Two pairs of single vision eyeglasses, one for distance vision and one for near vision, in lieu of bifocal eyeglasses, when bifocal lenses cannot be worn satisfactorily because of non-adaptation or safety reasons
- Single vision or bifocal eyeglasses for concurrent use with medically necessary contact lenses
- Low vision aids prescribed for visually impaired recipients
- Prosthetic eyes and prosthetic scleral shells
- Bandage contact lenses

**Non-Covered
Eye Appliances**

The following eye appliances are not Medi-Cal benefits:

- Eyeglasses used solely for protective, cosmetic, occupational or avocational purposes
- Spare pairs of eyeglasses
- Single vision eyeglasses in addition to multifocals
- Eyeglasses prescribed for other than the correction of refractive errors or binocularity anomalies
- Double segment bifocal or no-line multifocal lenses
- Multifocal contact lenses
- Eyeglasses to be used alternately with contact lenses

**Replacement of Lost,
Stolen, Broken or
Damaged Appliances**

Lost, stolen, broken or significantly damaged eye appliances may not be replaced unless a recipient or recipient's representative supplies the provider with a signed statement. The statement must certify that a loss, breakage or damage was beyond the recipient's control and must include the circumstances of the loss or destruction and the steps taken to recover the lost item. A recipient's signed statement about the circumstances of replacement must be retained in the recipient's file for at least three years.

Providers will not be held responsible for inaccurate statements by recipients. Providers may certify that specific items require replacement due to normal wear and tear or aging and that no abuse is evident. There are no time restrictions for replacement or repair of eye appliances.

Record Keeping

Providers must make a reasonable effort to ascertain and record the age, source and characteristics of a recipient's most recent ophthalmic correction. Reviewing provider records and asking recipients about prior ophthalmic corrections will satisfy this requirement.

Date Appliance Delivered

Welfare and Institutions Code Section 14043.341 requires providers to obtain and keep a record of Medi-Cal recipients' signatures when dispensing a product or prescription or when obtaining a laboratory specimen.

Therefore, dispensing optical providers (ophthalmologists, optometrists, and dispensing opticians) who dispense a device (eye appliances) requiring a written order or prescription must maintain the following items in their files to qualify for Medi-Cal reimbursement:

- Signature of the person receiving the eye appliance
- Medi-Cal recipient's printed name and signature
- Date signed
- Prescription number or item description of the eye appliance dispensed
- Relationship of the recipient to the person receiving the prescription if the recipient is not picking up the eye appliance

Undeliverable Custom-Made Appliances

When custom-made eye appliances cannot be delivered to recipients, providers must include documentation in the medical record that shows diligent attempts to make the delivery or the impossibility of delivery. Acceptable documentation would include, but not be limited to, certificate of mailing, telephone logs, etc.

Claims for custom-made eye appliances are reimbursed at 100 percent of the authorized maximum allowable. Providers must retain undeliverable custom-made eye appliances for one year from the date of service if reimbursement is received according to the conditions described above. These appliances must be ready for delivery on demand to the recipient or to a representative of the Department of Health Care Services (DHCS).

Prescription Requirements for Dispensing Providers

Providers who dispense the prescription of another provider must keep on record a current prescription with the prescriber's signature.

BILLING INFORMATION

Dispensing Fees for PIA Optical Laboratories

Providers in Prison Industry Authority (PIA) contracted counties are restricted to billing the following CPT-4 codes for dispensing of ophthalmic lenses for recipients who meet the exemptions as specified in the *Optional Benefits Exclusion* section in this manual:

<u>CPT-4 Code</u>	<u>Description</u>
92340	Fitting of spectacles, except for aphakia; monofocal
92341	Fitting of spectacles, except for aphakia; bifocal
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal
92352	Fitting of spectacle prosthesis for aphakia; monofocal
92353	Fitting of spectacle prosthesis for aphakia; multifocal

Refer to the *Rates: Maximum Reimbursement for Dispensing and Repair Fees* section, “Program Coverage” in the *Eyeglass Lenses* section, and the *Eyeglass Lenses: Examples* section of this manual for more information.

Eyeglass cases and frame adjustments, alignment and straightening are included in the Medi-Cal reimbursement for dispensing fees of ophthalmic lenses.

Lens Codes in Non-PIA Counties

For fee-for-service recipients in non-PIA contracted counties (San Luis Obispo [County 40], San Mateo [County 41] and Santa Barbara [County 42]), providers are instructed to bill ophthalmic lenses with HCPCS codes V2100 – V2499 and miscellaneous lens items with HCPCS codes V2700 – V2755, V2760 – V2762 and V2781 – V2784. Note: HCPCS codes V2118, V2218, V2219, V2315, V2318, and V2319 are non-covered benefits.

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Refer to the *Rates: Maximum Reimbursement for Eye Appliance* section in this manual for more information.

Note: Providers are instructed to use a private non-PIA optical laboratory for lens fabrication. In addition, providers are restricted from billing lens dispensing codes (CPT-4 codes 92340 – 92342 and 92352 – 92353) in counties 41 and 42.

Procedures

Eye appliances (HCPCS codes V2020 – V2629 and V2700 – V2799) and dispensing services (CPT-4 codes 92340 – 92342 and 92352 – 92353) must be billed on the *CMS-1500* claim form by dispensing optical providers (ophthalmologists, optometrists and dispensing opticians).

Providers must accept Medi-Cal’s maximum allowable as payment in full. Charges exceeding Medi-Cal allowances may not be billed to recipients.

Modifiers

To receive reimbursement, all eye appliances must be billed with an appropriate modifier on the *CMS-1500*. For a list of procedure codes and their corresponding modifiers, refer to the *Modifiers Used With Vision Care Procedure Codes* section in this manual.

In addition to the modifiers described in the *Optional Benefits Exclusion* section for long term care (beneficiaries receiving care in an NF-A, NF-B or ICF/DD), pregnancy-related and continuing care exemptions, modifiers required for billing eye appliances include:

<u>Modifier</u>	<u>Description</u>
NU	New equipment
RA	Repair/Replacement
KX	Specific required documentation on file (for trifocal and dispensing of trifocal lenses only)

Use modifier NU when supplying or dispensing eye appliances to recipients with no prior history of usage. Modifier RA is used to indicate replacement of eye appliances, which have been in use for some time.

Note: When both modifiers NU and RA are required for a service, use a separate claim line for each procedure code/modifier combination.

In addition to its usage for the billing of trifocal lenses, modifier KX is also used to indicate that the recipient’s residency exemption at skilled nursing facilities has been verified. Refer to the *Optional Benefits Exclusion* section in this manual for policy details regarding the usage of modifier KX.

ICD-9-CM Diagnosis Codes

ICD-9-CM diagnosis codes must be present and valid on all claims for the following eye appliance procedures for payment. For a list of procedures and their corresponding ICD-9-CM diagnosis codes, refer to the *Professional Services: Diagnosis Codes* section in this manual.

- Bandage contact lenses (HCPCS code V2599)
- Slab off prism (HCPCS code V2710)
- Tint, photochromic (HCPCS code V2744)
- Tint, solid, gradient, or equal (HCPCS code V2745)
- Ultra violet (UV) (HCPCS code V2755)

For the conditions specified below, primary and/or secondary ICD-9-CM diagnosis codes must be present and valid on all claims for frames, ophthalmic lenses, and/or lens dispensing fees to justify payment.

- When two pairs of single vision eyeglasses are prescribed in lieu of bifocals for recipients 38 years of age or older.
- When multifocal or nearpoint eyeglasses (in addition to the distance prescription) are prescribed for recipients younger than 38 years of age.

Additional Documentation

When frequency limits are exceeded, providers may be required to also submit the following documentation with claims for the repair or replacement of eye appliances:

- 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

Balance Lenses

Balance lenses ordered from PIA optical laboratories should be billed with the same procedure code for dispensing (CPT-4 codes 92341 – 92343 or 92352 – 92353) as for the lens that was prescribed for the sighted eye. For example, if a patient requires a balance lens with a bifocal prescription, CPT-4 codes 92341 should be billed with a quantity of “2.” Refer to the requirements listed under “Program Coverage” in the *Eyeglass Lenses* section of this manual.

When billing balance lenses in a non-PIA county, use the same ophthalmic lens code (HCPCS codes V2100 – V2499) as the code billed for the sighted eye. For example, if the patient requires a balance lens in a bifocal prescription in the range of 0 to 4 diopters, HCPCS code V2200 should be billed with quantity of “2.”

Note: HCPCS codes V2118, V2218, V2219, V2315, V2318, and V2319 are non-covered benefits.

Headbands

Claims for headbands require authorization and should be billed with HCPCS code V2799 (vision service, miscellaneous). Providers should include the following documentation in the *Medical Justification* field of the 50-3 *Treatment Authorization Request (TAR)* form:

- 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.

Refer to the *TAR Completion for Vision Care* section in this manual for instructions about completing the 50-3 *TAR* form.

Unlisted Eye Appliances

Unlisted eye appliances must be billed with HCPCS code V2799 (vision service, miscellaneous). Authorization for HCPCS code V2799 is required from DHCS VSB prior to dispensing the appliance. Providers must include a complete description of the appliance and justification for medical necessity in the *Medical Justification* field of the 50-3 *TAR* form. Because unlisted eye appliances are “By Report,” laboratory invoices or catalog pages detailing the wholesale cost of the eye appliances must be attached to the claim for manual pricing.

Note: Both modifier NU or RA and those modifiers described in the *Optional Benefits Exclusion* section for skilled nursing facility, pregnancy-related and continuing care exemptions are required when billing for HCPCS code V2799.

**Aphakia/Pseudophakia:
Medicare/Medi-Cal
Crossovers**

The Omnibus Budget Reconciliation Act of 1990 mandates limited coverage of eyewear for recipients with a diagnosis of aphakia (ICD-9-CM diagnosis codes 379.30 – 379.34 or 743.35) and pseudophakia (ICD-9-CM code V43.1).

Billing Medicare

All claims for eye appliances for recipients with aphakia must be billed to Medicare prior to billing Medi-Cal. For pseudophakic recipients, Medicare reimbursement is limited to one pair of conventional eyeglasses after cataract surgery with insertion of an intraocular lens implant. Claims for initial post-surgery eyeglasses for pseudophakic recipients must be billed to Medicare.

Medicare claims for eye appliances should be billed to Noridian Administrative Services, the Durable Medical Equipment Medicare Administrative Contractor. Refer to the *DME MAC Jurisdiction D Online Supplier Manual* for Medicare policy regarding lenses and frames.

Billing Medi-Cal

After Medicare benefits are exhausted, Medi-Cal will cover the replacement of ophthalmic lenses and frames or contact lenses, including changes in prescription, as well as lost, broken, stolen or scratched lenses for Medicare/Medi-Cal recipients who meet the exemptions specified in the *Optional Benefits Exclusion* section. Refer to the *Contact Lenses, Eyeglass Frames and Eyeglass Lenses* sections in this manual for more information.

When billing Medi-Cal for Medicare exhausted benefits, providers must enter a "1" (benefits exhausted) in the *Medicaid Resubmission Code* field (Box 22) on the *CMS-1500* and attach a copy of the *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* to the claim.

Note: Because the initial pair of post-surgery eyeglasses for pseudophakic recipients is billed to Medicare, providers must send the optical order to a non-PIA optical laboratory for lens fabrication. When billing for ophthalmic lenses, providers are instructed to use HCPCS codes V2100 – V2499 and when billing for miscellaneous lens items with HCPCS codes V2700 – V2755, V2760 – V2762 and V2781 – V2784. Lens dispensing fees (CPT-4 codes 92340 – 92342, and 92352 – 92353) should **not** be billed in this case.

HCPCS codes V2118, V2218, V2219, V2315, V2318, and V2319 are non-covered benefits.