

Eyeglass Lenses

This section contains information about eyeglass lenses and program coverage (*California Code of Regulations* [CCR], Title 22, Section 51317[c]). For a list of modifiers to be billed with eyeglass lenses, refer to the *Modifiers Used With Vision Care Procedure Codes* section in this manual.

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.

Program Coverage

In addition to the policy described in the *Optional Benefits Exclusion* section, prescription eyeglass lenses that conform to the American National Standards Institute (ANSI) Requirements for First Quality Prescription Lenses (Z80.1) are covered if the following criteria are met:

Single Vision Lenses

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

Multifocal Lenses

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.

Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals. Trifocal lenses for first-time wearers are not a Medi-Cal benefit.

Replacement Lenses

Replacement lenses must meet the criteria for single vision and multifocal lenses and one or more of the following:

- The power is changed at least 0.50 diopters in any corresponding meridian.
- The cylinder axis is changed 20 degrees or greater for cylinder power of 0.50 – 0.62 diopters, 15 degrees or greater for cylinder power of 0.75 – 0.87 diopters, 10 degrees or greater for cylinder power of 1.00 – 1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12 – 0.37 diopters, as the sole reason for change, is not covered.
- The prismatic differential correction is changed at least 0.75 prism diopters in the vertical meridian or at least 1.5 prism diopters in the horizontal meridian.
- The previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety. Refer to the *Eye Appliances* section in this manual for required documentation of replacement lenses.
- The lenses are replaced because a different frame size or shape is necessary due to patient growth, metal allergy or other justifiable medical reasons.

Lens Benefits Requiring Authorization

The following HCPCS codes for ophthalmic lenses and lens-related items require an approved *Treatment Authorization Request (TAR)* and must be billed with either modifier NU (new equipment) or RA (replacement) in addition to the modifiers for long term care, pregnancy-related and continuing care exemptions described in the *Optional Benefits Exclusion* section. Authorization requests for these items must be submitted on the 50-3 TAR form with supporting medical justification. If authorized, these ophthalmic lens orders must be fabricated at a non-PIA (Prison Industry Authority) optical laboratory.

<u>HCPCS Code</u>	<u>Description</u>
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

* See "Polycarbonate Lenses" in this section for policy and billing guidelines.

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.

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:

<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

For more information refer to “Program Coverage” in this section. see the *Rates: Maximum Reimbursement for Dispensing and Repair Fees* and *Eyeglass Lenses Examples: CMS-1500* sections of this manual.

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.

Refer to the *Rates: Maximum Reimbursement for Eye Appliances* 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

Ophthalmic lenses (HCPCS codes V2100 – V2499), miscellaneous lens items (V2700 – V2799) and dispensing services (CPT-4 codes 92340 – 92342 and 92352 – 92353) must be billed on the *CMS-1500* by dispensing optical providers (ophthalmologists and dispensing opticians).

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

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

Modifiers

In addition to the modifiers for long term care (beneficiaries receiving care in an NF-A, NF-B or ICF/DD), pregnancy-related and continuing care exemptions described in the *Optional Benefits Exclusion* section, ophthalmic lenses and lens dispensing fees must be billed with an appropriate modifier on the *CMS-1500* for payment. One of the following modifiers is required for billing ophthalmic lenses and lens dispensing fees:

<u>Modifier</u>	<u>Description</u>
NU	New equipment
RA	Replacement
KX	Specific required documentation on file

Modifier NU is used when supplying or dispensing ophthalmic lenses to recipients with no prior history of usage. Modifier RA is used to indicate replacement of ophthalmic lenses.

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

Because trifocal lenses are covered only for recipients who are current trifocal wearers, the appropriate code (HCPCS codes V2300 – V2321 for trifocal lenses and CPT-4 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..

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ICD-9-CM Diagnosis Codes

ICD-9-CM diagnosis codes must be present and valid on all claims for the following ophthalmic lens codes 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.

- Slab off prism (HCPCS code V2710)
- Tint, photochromic (HCPCS code V2744)
- Tint, solid, gradient, or equal (HCPCS code V2745)
- Ultraviolet (UV) (HCPCS code V2755)

Absorptive Lenses

Absorptive lenses (tinted and photochromatic lenses), which reduce the amount of light energy reaching the eye or selectively restrict the passage of specific parts of the light spectrum and that meet the criteria for single vision, multifocal and replacement lenses are covered under any of the following conditions:

- Eye pathology aggravated by exposure to light is present.
- The normal eye protective system that guards against light is impaired.
- Chronic pathological conditions intensified by exposure to light energy are present.

Plastic tinted or photochromatic lenses can be ordered from the Prison Industry Authority (PIA) optical laboratory. To order, providers must indicate the ICD-9-CM diagnosis code of the patient's condition in the *Special Instructions* field of the *California Prison Industry Authority Optical Order Form* or on the PIA online ordering Web site (<https://optical.pia.ca.gov/pool/>). (Refer to the *PIA Optical Laboratories: Order Form Completion* section in this manual for more information.)

Note: Plastic photochromatic lenses (transition lenses) are covered when medically justified and the requirements listed under "Program Coverage" in this section are met. In addition, the following criteria must also be met:

- The recipient currently wears transition or photogrey lenses previously ordered from PIA or is younger than 18 years of age. In each case, the recipient must meet the diagnosis code requirements as indicated in the *Professional Services: Diagnosis Codes* section in this manual
- The recipient is visually impaired (ICD-9-CM codes 369.00 – 369.9) or has a visual field defect (ICD-9-CM codes 368.40 – 368.47)
- A valid authorization exists from the Department of Health Care Services (DHCS) Vision Services Branch (VSB).

Providers must be signed up on the PIA online ordering Web site to order transition lenses.

Billing Absorptive Lenses

When absorptive lenses (photochromatic, tints or UV) are ordered at the PIA optical laboratory for patients who meet the medical necessity requirements mentioned above, providers are restricted to billing only lens dispensing fees (CPT-4 codes 92340, 92341, 92342, 92352 and 92353). Because these lenses are provided at no charge to the provider, HCPCS codes V2744, V2745 and V2755 are not covered in PIA counties and should not be billed in addition to lens dispensing fees.

In non-PIA counties, HCPCS codes V2744, V2745 and V2755 must be billed with a valid ICD-9-CM diagnosis code for payment. Refer to the *Professional Services: Diagnosis Codes* section in this manual for a list of required diagnosis codes and their corresponding procedures.

Polycarbonate Lenses

Polycarbonate lenses can be fabricated at the PIA optical laboratories without a TAR for recipients younger than 18 years of age, and for recipients 18 years of age or older who meet the following criteria:

- Visual impairment in one or both eyes. Visual impairment is defined as visual acuity with optimal correction equal to or poorer than 0.30 decimal notation or 20/60 Snellen, or equivalent at specified distances, or when either visual field is limited to ten degrees or less from the point of fixation in any direction.

Because polycarbonate lenses are fabricated at the PIA optical laboratories for Medi-Cal recipients who meet the above criteria, dispensing optical providers (optometrists, ophthalmologists and dispensing opticians) should bill only lens dispensing fees (CPT-4 codes 92340, 92341, 92342, 92352 or 92353). HCPCS code V2784 (lens, polycarbonate or equal, any index, per lens) should not be billed in addition to the lens dispensing fees in this case.

For all other conditions and in those instances when polycarbonate lenses cannot be fabricated at the PIA laboratory, a *Treatment Authorization Request* (TAR) is still required and must be submitted on the 50-3 TAR form for fabrication at a non-PIA or private optical laboratory. In such instance, HCPCS code V2784 with appropriate modifier should be included on the 50-3 TAR form during TAR submission.

Refer to the *TAR Completion for Vision Care* section of this manual for more information about completing the 50-3 TAR form.

Providers billing HCPCS code V2784 to California Children's Service/Genetically Handicapped Persons Program (CCS/GHPP) must have authorization from CCS/GHPP through a *Service Authorization Request* (SAR) or CCS Legacy authorization.

Balance Lenses

A balance lens is covered when the corrected visual acuity in the poorer eye is 0.10 decimal notation (20/200 Snellen or equivalent) or worse.

Balance lenses that are 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 code 92341 should be billed with a quantity of “2.” Refer to the requirements listed under “Program Coverage” previously discussed in this section.

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.

Non-PIA Covered Lenses

Non-PIA covered lenses must be billed with HCPCS code V2799 (vision service, miscellaneous). Authorization for HCPCS code V2799 is required from the 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 (Box 8C) of the 50-3 TAR form or on a separate attachment. Unlisted eye appliances are “By Report”; therefore, laboratory invoices or catalog pages detailing the wholesale cost of the eye appliances must be attached to the claim for manual pricing.

Note: Either modifier NU or RA is required when billing for HCPCS code V2799.

Single Vision Eyeglasses
in Lieu of Bifocals

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.

Billing

When billing two pairs of single vision eyeglasses in lieu of bifocals for recipients 38 years of age and older who meet the exemptions as specified in the *Optional Benefits Exclusion* section in this manual, providers must enter ophthalmic single vision lens (HCPCS codes V2100 –V2115, V2121, V2410) in non-PIA counties and single vision lens dispensing fees (CPT-4 codes 92340 and 92352) on the same claim line with four units and include the following ICD-9-CM primary diagnosis code and one of the following secondary diagnosis codes on the claim:

- Primary
 - 367.4 Presbyopia
- Secondary
 - 368.10 Subjective visual disturbance
 - 368.13 Visual discomfort
 - 368.14 Visual distortions in shape and size
 - 368.15 Other visual distortions and entopic phenomena
 - 368.16 Psychophysical visual disturbances
 - 368.8 Other specified visual disturbances
 - 368.9 Unspecified visual disturbance

Multifocal and Nearpoint Prescription for Recipients Younger than 38 Years of Age

All multifocal or nearpoint lenses (in addition to the distance prescription) must be justified for recipients younger than 38 years of age on the date of service who meet the exemptions as specified in the *Optional Benefits Exclusion* section in this manual.

When billing for two pairs of single vision eyeglasses in lieu of bifocals for recipients younger than 38 years of age, providers must bill ophthalmic lenses in non-PIA counties or lens dispensing fees in PIA counties on the same claim line with four units, document the need for the eyeglasses in the medical record and include one of the following ICD-9-CM diagnosis codes as a primary diagnosis code on the claim:

- 367.51 Paresis of accommodation
- 367.52 Total or complete internal ophthalmoplegia
- 367.53 Spasm of accommodation
- 367.9 Unspecified disorder of refraction and accommodation
- 378.35 Accommodative component in esotropia
- 378.84 Convergence excess or spasm

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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 ophthalmic lenses in non-PIA counties and lens dispensing fees in PIA counties:

- 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

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:

- Medi-Cal 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

Fresnel Prisms

Fresnel prisms are a benefit when prescribed to fully or partially compensate a phoric or tropic condition. Fresnel prisms are not covered when used for orthoptic, pleoptic or other vision training purposes.

Fresnel prisms can be ordered from a PIA optical laboratory. To order, enter the prescription information in the *Special Instructions* field of the PIA optical order form or through the PIA Optical Online Web site. (Refer to the *PIA Optical Laboratories: Order Form Completion* section in this manual for more information.)

Billing

For Fresnel prisms that are ordered from the PIA optical laboratory, no additional billing is required. In non-PIA counties, Fresnel prisms should be billed with HCPCS code V2718 (prism, per lens).

Lenses Reimbursable For Recipients with Other Health Coverage

HCPCS codes V2100 – V2499 and V2700 – V2790 (eyeglass lenses or miscellaneous lens items) are reimbursable for recipients with Other Health Coverage (OHC) when the Scope of Coverage (COV) code is “V” or “Comprehensive” and the provider has proof of one of the following:

- OHC ineligibility
- Service is not a benefit of the recipient’s OHC plan

Proof may be in the form of an OHC denial letter or *Explanation of Benefits*, provided that the document covers the same procedure code and the same date of service and the document is not older than 365 days prior to the date of service on the claim. Photocopies are acceptable.

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

Provider Lens Acquisition

Eyeglass lenses (HCPCS codes V2100 – V2499 and V2700 – V2790) must be ordered by providers at a private or non-PIA optical laboratory when the original arrangement was with an OHC intermediary. The PIA optical laboratories will not process optical orders for recipients with OHC and COV: “V” or “Comprehensive”.

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