15

15 Eye Care Services

Medicaid pays for certain eye care services provided by participating Optometrists, Opticians, and Ophthalmologists.

Ophthalmologists may refer to Chapter 28, Physician, for additional information.

Medicaid also contracts with a Central Source contractor who is responsible for providing lenses and frames for Medicaid recipients. At the option of the provider taking the frame measurements, eyeglasses may be obtained from the Central Source or from any other source. Medicaid will pay no more than the contract price charged by the Central Source. Sample kits are available (frames and display containers) which can be purchased by eye care practitioners at the contractor's cost of frames plus mailing. Currently, the Central Source contractor is Classic Optical. Classic Optical's phone number is 1 (888) 522-2020 and the website address is www.classicoptical.com.

The policy provisions for eye care providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 17.

15.1 Enrollment

HP enrolls eye care providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as an Eye Care provider is issued a 10-digit National provider Identifier (NPI) that enables the provider to submit requests and receive reimbursements for eye care related claims.

A provider who contracts with Alabama Medicaid as an eye care provider is added to the Medicaid system with the NPI provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for eye care related claims.

NOTE:
All nine digits are required when filing a claim.

Opticians are assigned a provider type of 18. Optometrists are assigned a provider type of 19. Valid specialties for Eye Care providers include the following:

Optician (190)

Optometrist (180)

Ophthalmologists are enrolled with a provider type of 31 (Physician). The valid specialty is Ophthalmologist (330).

Enrollment Policy for Eye Care Providers

To participate in Medicaid, eye care providers must have current certification and be licensed to practice in the state of Alabama, allowed by their licensing board and the laws of State of Alabama.

To prescribe therapeutic agents for the eye, the optometrist must be appropriately licensed by the Alabama Board of Optometry.

Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:

    (i) Eyeglasses,

    (ii) Comprehensive Audiological services,

    (iii) Comprehensive Opthalamological services,

    (iv) Patient 1st and EPSDT Referrals,

(g) Shall not bill Medicaid for services which are offered to anyone for free. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

15.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

This section also discusses the types of eye examinations covered by Medicaid and describes the standards and procedures used to provide eyeglasses.

NOTE:

The Agency establishes annual benefit limits on certain covered services. Benefit limits related to eye care services are established every two calendar years for recipients 21 years of age or older. Therefore, it is imperative Eye Care Providers/Contractors furnishing services to recipients 21 years of age and older, verify benefit limits for the current year and the past year to determine if the eye care benefit limits have been exhausted. Providers/Contractors who do not verify benefit limits for two calendar years (last year and current year) for recipient's 21 years of age and older risk a denial of reimbursement for those services. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

NOTE:

Prior authorized (PA) frames, lenses, exams, and fittings are now posting to the benefit limits screen. It is imperative to verify eligibility and benefit limits prior to rendering services. Please refer to Chapter 3, Verifying Recipient Eligibility for details.

15.2.1 Examinations

Medicaid eye care providers may administer and submit claims for several kinds of examinations, including the following:

- Examination for refractive error
- Optometrist services other than correction of refractive error
- Physician services

Providers may render services to Medicaid recipients confined to bed in a health care facility if the patient's attending physician documents that the patient is unable to leave the facility and that the examination is medically necessary.

Examination for Refractive Error

Medicaid recipients 21 years of age and older are authorized one complete eye examination and work-up for refractive error every two calendar years. Recipients under 21 years of age are authorized the same service each calendar year or more often if documented medical necessity indicates.

Complete Eye Examinations

The appropriate procedure codes to use when filing claims for a complete eye examination and refractive error work-up are codes 92004 and 92014.

A complete eye examination and refractive error work-up includes the following services:

- Case history review
- Eye health examination
- Visual acuity testing
- Visual fields testing (if indicated)
- Tonometry
- Eyeglasses prescription (if indicated)
- Determination of optical characteristics of the lenses (refraction)

Examiners use the appropriate diagnosis code(s) to indicate the diagnosis.

NOTE:

For children, examine eye tension and visual fields only if indicated.

Please refer to Section 15.5.3 for additional information.

Optometrist Services

Optometrists may provide services other than correction of refractive error as follows:

- During an eye examination, if the optometrist suspects or detects irregularities requiring medical treatment that is not allowed by state law to be provided by an optometrist, the optometrist refers the case to an appropriate doctor of medicine or osteopathy.
- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Photochromic lenses and UV400 coating require prior authorization.
- Post-operative cataract patients may be referred, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Refer any subsequent abnormal or unusual conditions diagnosed during follow-up care back to the ophthalmologist.

- Artificial Eyes

Physician Services

Physicians may provide the following eye care services when diseases, injuries, or congenital defects are present:

- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.
- Artificial Eyes

15.2.2 Eyeglasses

If a Medicaid recipient requires eyeglasses, services include verification of prescription, dispensing of eyeglasses, frame selection, procurement of eyeglasses, and fitting and adjustment of the eyeglasses to the patient.

Recipients 21 years of age and older are authorized one pair of eyeglasses each two calendar years if indicated by an examination. Prior authorization is required for additional glasses within same benefit period. Recipients under 21 years of age are authorized the same service each calendar year, or more often if documented medical necessity indicates. These limitations also apply to fittings and adjustments.

Any exception to these benefit limits must be based on medical necessity and the reasons documented in the medical record. Examples of medical necessity could be for treatment of eye injury, disease, significant prescription change, or unrepairable damage to glasses. Additional eyeglasses can not be authorized for convenience but only for clearly documented medically necessary reasons. An example for convenience may be more than one (1) pair of eyeglasses.

At the option of the provider taking the frame measurements, either the Medicaid Central Source or any other source may provide eyeglasses that conform to Medicaid standards. Medicaid will pay no more than the contract price charged by the Central Source.

Frame Standards

See Section 15.5.3, Procedure Codes and Modifiers, for frame procedure codes and contract prices.

The authorized frames, or frames of equal quality, are provided for Medicaid recipients at the contract prices shown on the list. Under normal circumstances, the date of service for eyeglasses is the same as the date of examination. All frames must meet American National Standards Index (ANSI) standards. This information and color photos of the frames are also available to view and to download at the website of the Central Source (www.classicoptical.com).

Lens Standards

Lens specifications are authorized at the specified contract price. See Section 15.5.3, Procedure Codes and Modifiers, for lens procedure codes and contract prices.

Lenses are composed of clear glass or clear plastic unless prior authorized by Medicaid because of unusual conditions. All lenses must meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements.

Spherical lenses must have at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (no other error) is 0.50 diopter.

New Lenses Only

Patients who have old frames that meet the above standards may have new lenses installed instead of receiving new eyeglasses. Medicaid will pay for the lenses only.

Include the following statement in the patient’s record: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

New Frame Only

Patients who have old lenses that meet the above standards may have them installed in a new frame instead of receiving new eyeglasses. Medicaid will pay for the frame only.

Include the following statement on the patient’s record: "I hereby certify that I used this patient's old lenses and that I did not accept any remuneration therefore."

Patient Requests Other Eyeglasses

If a patient chooses eyeglasses other than those provided by Medicaid, the patient must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for the patient's record: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

Additional Eyeglasses and Eye Exams

If medically necessary, Medicaid may prior authorize additional eye exams and eyeglasses for treatment of eye injury, disease, significant prescription change, or other circumstances resulting in unusable glasses/lenses. The provider should forward an electronic PA request or an Alabama Prior Review and Authorization Request (Form 342) with a letter justifying necessity to HP prior to ordering the eyeglasses.

Replacement of Glasses

When a patient presents to your office requesting replacement of glasses for medically necessary reasons or unrepairable damage to glasses within the benefit limit period, the following instructions should be followed. For patients 21 years of age or older, prior authorization is required for additional glasses above the benefit limit of 1 pair of glasses each two (2) calendar years. Patients less than 21 years of age are authorized additional services when

medically necessary and documentation in the medical record supports medical necessity, without a prior authorization.

When it is determined that a second pair of glasses is medically necessary or unrepairable, the block on Classic Optical's job order form entitled "Date of Exam/Order" must have the date the patient returned to your office as opposed to the original date of the eye examination. This date will represent the "order" date. If the date of the original examination is transcribed, Classic's claim will deny.

If this is a recent replacement and does not necessitate another eye exam, you are not required to perform another eye exam.

If the replacement reason is necessary due to warranty or workmanship reasons and within 90 days of the original issue of eyeglasses, contact Classic Optical at 1(888) 522-2020 for replacement at no cost.

Ordering Frames, Lenses and Eyeglasses

As provided in Section 15.2.2 above, providers may order eyeglasses from the Central Medicaid source, Classic Optical, or any other source that conforms to Medicaid standards.
From the Central Source, providers can place orders electronically via the Internet at www.classicoptical.com, fax 1(888) 522-2022 or mail. To enhance the effectiveness and efficiency of eyeglass ordering, the Central Source recommends for providers to order eyeglasses electronically via the Internet at www.classicoptical.com. There is no additional charge for placing eyeglass orders electronically. The benefits of ordering via the internet include:

- Quicker order processing and turnaround
- Immediate order correction via online **SMART Order Form®** which prevents ordering non-contract items and impossible ophthalmic combinations
- Immediate e-mail response order confirmation
- Ability to print copy of Rx order
- Improved access to information including date of next eligible vision benefit
- Access to Recipient Vision Profile Screen
- Ability to track orders including confirm expected ship date
- Ability to view backorder frames
- Online frame catalogue (view and print frame photos)
- Stock frame **SMART Order Form®** online ordering
- Answers to Alabama Medicaid Vision Program Frequently Asked Questions

Visit www.classicoptical.com to view these benefits or call a Classic Optical Tech Rep at 1(888) 522-2020 to get a username and password to access these functions. For complete instructions for ordering via the internet visit www.classicoptical.com.

NOTE:

When the Central Source provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the Central Source may submit claims for these services.

Completing the Paper Eyeglass Prescription Form

Paper Eyeglass prescription forms are available from the Central Source, upon request. When the Central Source provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the Central Source may submit claims for these services.

Field on Form	***Information To Enter***
Provider Number	Enter ordering NPI
Date	Enter only the date of service or date of prior authorization letter. Do not enter any other dates.
Eyeglasses Prescription Information	Enter the prescription in the appropriate fields provided.
P.D. Far-Near	Indicate as appropriate.
Eye	Enter appropriate measurement.
Bridge	Enter appropriate measurement.
Seg Height	Enter appropriate measurement.
Type Lenses	Indicate plastic or glass.
Temple Length	Enter appropriate measurement.
SV	Check appropriate block.
Frame	Enter appropriate frame name and color.
Special Instructions	Indicate as applicable.
Insurer's ID Number or RID number	Enter the 13-digit RID number from the recipient's plastic Medicaid card. Please verify this information. The Eyeglass Central Source is dependent upon the examiner for this vital information. Failure to furnish accurate information may delay or deny payment to the Medicaid Central Source.
Patient name	Enter the patient's last name, first name, and middle initial as it appears on the plastic Medicaid card.
Date of Birth	Enter patient's date of birth.
Patient's Address	Enter address
Patient or Authorized Person's Signature/Doctor's Signature	Have patient or patient's authorized representative sign and indicate the doctor's signature.
Prior Authorization	If services performed require prior authorization, indicate the ten-digit number supplied by Medicaid.
Provider	Enter the provider name and address to which the Central Source will deliver the completed eyeglasses.

The provider keeps the pink copy and forwards the other copies to the Central Source. The remainder of the form will be completed by the Central Source. Providers may submit paper order forms by faxing to Classic Optical at 1(888) 522-2022, or by mail, to Classic Optical at P.O. Box 1341, Youngstown, Ohio 44501. For inquiries on your order or to order by phone, you may contact Customer Service at Classic Optical at 1(888) 522-2020.

15.3 Prior Authorization and Referral Requirements

The Medicaid program requires that Medicaid give authorization prior to the delivery or payment of certain eye care services. Refer to Chapter 4, Obtaining Prior Authorization, for information about requesting prior authorization.

Prior authorization from Medicaid is required for the following eye care services:

- Lens and frame change in same benefit period
- Orthoptic training (eye exercises)
- Additional comprehensive exams in same benefit period
- Photochromic lenses
- UV 400 lens coating
- Low vision aids
- Contact lenses (for anisometropia, keratoconus, aphakia, and high magnification difference between lenses)
- Progressive Lenses

All requests for prior authorization should include the following information:

1. Recipient's name
2. Recipient's Medicaid Number (thirteen-digits)
3. If the PA is requested due to a prescription change, past and current prescription data (complete for both eyes), including diagnosis code(s), is required
4. Exception requested (what is being requested)
5. Reason for exception (explain, e.g., cataract surgery date, etc…), with current justification
6. Signature of practitioner
7. Address of practitioner

Refer to Section 15.5.3, Procedure Codes and Modifiers, for the appropriate procedure codes for services requiring prior authorization.

Other Situations

Providers may render special services for unusual situations upon prior authorization. Medicaid must receive full, written information justifying medical necessity prior to the service being rendered. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

Patient 1st Referral Requirements

The following ranges of procedure codes (including routine vision exams, eyeglasses, fittings, and lenses) **do not require a referral** for Patient 1st recipients:

Procedure Code	*Description*
V0100-V2799	CMS Assignment of Vision Services
V2020	Eyeglasses, Frames
V2025	Eyeglasses, Special Order Frames
92002-92015	Ophthalmological services for new or established patients
92313	Corneoscleral lens
92315-92317	Corneal lens/Corneoscleral lens
92326	Replacement of lens

Refer to Chapter 39, Patient 1st, for more information on Patient 1st requirements.

Eyeglass Contractors

If the Central Source provides eyeglasses, send them a copy of the approval letter from Medicaid bearing the ten-digit prior authorization number.

15.4 Cost Sharing (Copayment)

The copayment amount for optometric office visits is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.
The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

15.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit

Eye care providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

This section explains how to file claims for the following situations:

- Eye examination only
- Eye examination and fitting by one provider, eyeglasses from the Central Source
- Fitting only, eyeglasses from the Central Source
- Post-operative care
- Ophthalmoscopy extended (92225) and subsequent (92226)
- Other situations

NOTE:

Providers who furnish services should only bill for those services provided. Please be aware when filing claims that the claim reflects services actually rendered/provided. Billing for services not provided could be considered fraudulent. Please ensure your billing staff is aware of appropriate billing practices.

Routine Checkups and Medicare

Medicare routinely covers eye care services for medical eye conditions (i.e. glaucoma, cataracts, diabetes, etc.). For dual eligibles (recipients with Medicare and Medicaid), Medicaid is the payer of last resort. For medical eye conditions, Medicare should be billed first for consideration of payment. Upon Medicare payment, the crossover form and information should be forwarded to HP for consideration of Medicaid payment. Should Medicare deny payment for a medical eye condition, seek all corrective Medicare remedies to ensure payment.

Medicare does not cover routine “Examination of Eyes and Vision” for a non medical reason. When non-medical and routine “Examination of Eyes and Vision” services are denied by Medicare, claims should be sent to the Medical Support unit at the Alabama Medicaid Agency within 120 days of the Medicare EOMB date. The claim must have Medicare denial attached. These claims require manual review for appropriateness and will be overridden when indicated.

Eye Examination Only

When the Medicaid recipient undergoes an eye examination only, the examiner completes a claim that specifies "Complete Eye Examinations and Refraction."

If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code or office visit code. Refer to 15.5.3, Procedure Codes and Modifiers, for a list of possible procedure codes. Send this claim directly to HP.

Eye Examination and Fitting by One Provider, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs an eye examination (including refraction) and fitting (including frame service, verification, and subsequent service) and the central Medicaid source contractor provides the eyeglasses.

1. The examiner completes the CMS-1500 claim form, separately identifying the examination, refraction, and fitting. The examiner does not bill lenses and frames.
2. The examiner forwards the Medicaid job order form reflecting all necessary prescription data, including frame required, to the Central Source.
3. The contractor fills the prescription and returns the eyeglasses to the examiner for delivery to the patient. The Patient or Authorized Signature box must be complete with the appropriate signature or the statement "Signature on file."
4. The Central Source contractor submits claims for payment to HP.

When eyeglasses are NOT procured from the Central Source contractor, the claim should separately specify charges for the examination performed, refraction, fitting, lenses, and frame.

When Opticians provide eyeglasses, the claim should identify only the fitting service, lenses, and frame. The claim is sent directly to HP. Lenses and frames are reimbursed at the Central Source contract prices.

Fitting Only, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs a fitting (including frame service, verification, and subsequent service) and the Central Source contractor provides the eyeglasses.

The provider completes a claim that specifies the fitting services only. Send claims for payment directly to HP.

Post-Operative Care

Medicaid will not process post-operative management claims until the referring ophthalmologist has received payment for surgery. The surgeon must first submit a modifier 54 with the appropriate surgical code. The optometrist should then submit a modifier 55 with the appropriate surgical code after the ophthalmologist has been paid in order to be paid for post-operative care.

Medicaid will deny post-operative claims when the surgeon (ophthalmologist) receives payment for the global amount. It is the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.

Ophthalmoscopy extended (92225) and subsequent (92226)

Ophthalmoscopy extended (92225) and subsequent (92226) are considered reasonable and necessary services for example, evaluation of tumors, retinal tears, detachments, hemorrhages, exudative detachments, retinal defects without detachment, and other ocular defects for the meticulous evaluation of the eye and detailed documentation of a severe ophthalmologic problem

when photography is not adequate or appropriate. A serious retinal condition must exist, or be suspected, based on routine ophthalmoscopy which requires further detailed study. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. Accordingly, medical record documentation should be recorded in the patient's medical record.

15.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

15.5.2 Diagnosis Codes

The International Classification of Diseases Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

15.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed by Medicare

The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

This section lists procedure codes for optometric services and equipment arranged by type of service or equipment:

- Common Optometric services
- Special Optometric services
- Contact lenses
- Eyeglasses codes

Services requiring prior authorization are identified in the Prior Authorization column (PA Required).

To report intermediate, comprehensive, and special services, use the specific ophthalmological description.

Common Optometric Services

The Optometric Services listed below are those commonly used by Optometrists and Ophthalmologists. Procedure codes 92004 and 92014 should include a complete eye exam and work-up as outlined in Section 15.2.1.

Procedure Code	***Description***
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Comprehensive, established patient, one or more visits
92015	Determination of refractive state (Bill as an add-on charge with complete eye exam when refraction is accomplished)
99201	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A problem-focused history • A problem-focused examination; and • Straightforward medical decision making
99202	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components • An expanded problem-focused history • An expanded problem-focused examination; and • Straightforward medical decision making
99203	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A detailed history • A detailed examination; and • Medical decision making of low complexity
99204	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of moderate complexity
99205	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of high complexity
99211	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A problem-focused history • A problem-focused examination • Straightforward medical decision making

Procedure Code	*Description*
99213	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • An expanded problem-focused history • An expanded problem-focused examination • Medical decision making of low complexity
99214	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A detailed history • A detailed examination • Medical decision making of moderate complexity
99215	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity

Miscellaneous Procedures

Procedure Code	*Description*
99241	Office consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99242	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making
99251	Initial inpatient consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99252	Initial inpatient consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making
99261	Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity
99262	Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity

Procedure Code	*Description*
99311	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity
99312	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity
99313	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A detailed interval history • A detailed examination • Medical decision making of moderate to high complexity

Special Optometric Services

Procedure Code	*Description*	*PA Required*
92018	Opthalmological examination and evaluation under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic evaluation	No
92019	Limited	No
92020	Gonioscopy (separate procedure)	No
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	No
92065	Orthoptic training and/or pleoptic training, with continuing medical direction and evaluation (requires prior authorization from Medicaid)	Yes
92070	Fitting of contact lens for treatment of disease, including supply of lens	No
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
92082	Intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	No
92083	Extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 300	No
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
92136	Opthalmic biometry by partial coherence interferometry with intraocular lens power calculation	No
92140	Provocative tests for glaucoma, with interpretation and report, without tonography	No

Procedure Code	Description	PA Required
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	No
92226	Subsequent	No
92230	Florescein angioscopy with interpretation and report	No
92250	Fundus photography with interpretation and report	No
92260	Opthalmolodynamometry	No
92270	Electro-oculography with interpretation and report	No
92275	Electroretinography with interpretation and report	No
92283	Color vision examination extended, e.g., anomaloscope or equivalent	No
92284	Dark adaptation examination with interpretation and report	No
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	No
92330	Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation	No
92335	Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation	No
92340	Fitting of spectacles, except aphakia; monofocal	No
92341	Bifocal	No
92342	Multifocal, other than bifocal	No
92352	Fitting of spectacle prosthesis for aphakia; Monofocal	No
92353	Multifocal	No
92354	Fitting of spectacle mounted low vision aid; single element system	No
92355	Telescopic or other compound lens system	No
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	No
92370	Repair and refitting spectacles; except for aphakia	No
92371	Spectacle prosthesis for aphakia	No
92390	Supply of spectacles, except prosthesis foe aphakia and low vision aids	No
92391	Supply of contact lenses, except prosthesis for aphakia	Yes
92392	Supply of low vision aids (A low vision aid is any lens or device used to aid or improve visual function in a person whose vision cannot be normalized by conventional spectacle correction. Includes reading additions up to 4D)	Yes
92393	Supply of ocular prosthesis (artificial eye)	No
92395	Supply of permanent prosthesis for aphakia; spectacles	No
92396	Contact lenses	Yes

Surgical Procedures

Procedure Code	Description
65205*	Removal of foreign body, external eye; conjunctival superficial
65210*	Conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220*	Corneal, without slit lamp
65222*	Corneal, with slit lamp
68801*	Dilation of lacrimal punctum, with or without irrigation

Procedure Code	Description
68810*	Probing of nasolacrimal duct, with or without irrigation

* Service Includes Surgical Procedure Only

Post Operative Care Modifiers

Use the appropriate modifier identifying post-operative management when submitting claims.

1st Modifier	Description
55	Postoperative Management (Optometrist)
54	Surgical Care (Opthamologist)
2nd Modifier	**Description**
RT	Right Eye
LT	Left Eye

Contact Lenses

Contact lenses may be provided for post-cataract surgery, anisometropia, keratoconus treatment, and high magnification difference between lenses. Fitting services are billed as a separate billed item. Lenses are billed per lens. Prior authorization is required for lenses and fitting services.

Procedure Code	Modifier, If Applicable	Description	PA Required
V2510		Contact lens, gas permeable, spherical	Yes
V2511		Contact lens, gas permeable, toric	Yes
V2512		Contact lens, gas permeable, bifocal, per lens	Yes
V2513		Contact lens, gas permeable, extended wear	Yes
V2520		Contact lens, hydrophilic, spherical	Yes
V2521		Contact lens, hydrophilic, toric	Yes
V2523		Contact lens, hydrophilic, extended wear	Yes
92310	52	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	Yes
92311		Corneal lens for aphakia, one eye	Yes
92312		Corneal lens for aphakia, both eyes	Yes
92313		Corneoscleral lens	Yes
92314		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	Yes
92315		Corneal lens for aphakia, one eye	Yes
92316		Corneal lens for aphakia, both eyes	Yes
92317		Corneoscleral lens	Yes
92325		Modification of contact lens (separate procedure), with medical supervision of adaptation	No
92326		Replacement of contact lens	Yes

Eyeglasses Codes

At the option of the provider making the frame measurements, eyeglasses that conform to Medicaid standards may be procured from either the Central Source or from any other source. However, Medicaid will pay only the contract price charged by the Central Source.

Use the procedure codes and prices listed below for lenses. Add-on lens treatments requiring prior authorization are listed separately.

The lens specifications below are authorized at the specified contract price. Lenses must meet FDS impact-resistant regulations and must be made of glass or clear plastic except when other materials are prior authorized by Medicaid for unusual conditions. Spherical lenses must be at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (with no other error) is 0.50 diopter.

Procedure codes are listed in the following order:
Lens Codes

- Single vision
- Bifocal sphere
- Bifocal spherocylinder cylinder
- Other lenses
- Lenses requiring prior authorization from Medicaid before ordering.

The frame specifications below are authorized at the specified contract price. Effective July 1, 2002, the locally assigned procedure codes for frames are converted to one of two codes (PC), V2020 and V2025. A special order frame is designated as V2025 and should be billed as $25.00. Procedure code V2020 is designated for all the other frame codes and **the amount billed should be according to the frame provided**. In other words, **providers should bill the price of the frame in this manual and not their usual and customary price for the frame.**

Frame Codes

- Women's frames
- Girls' frames
- Men's frames
- Boys' frames
- Unisex frames for men, women, boys, or girls
- Special frame (size, type) other than above

Single Vision Spherocylinder (Plus or Minus)

Single Vision (Plus or Minus)	*Price Per Lens*
V2100 – Plano – 4.00	$5.00
V2101 – 4.25 – 7.00	5.72
V2102 – 7.25 – 12.00	8.02
V2103 – Plano – 4.00/0.25 – 2.00 cylinder	5.10
V2104 – Plano – 4.00/2.25 – 4.00 cylinder	5.10
V2105 – Plano – 4.00/4.25 – 6.00 cylinder	7.72
V2106 – Plano – 4.00/over 6.00 cylinder	7.99
V2107 – 4.25 – 7.00/0.25 – 2.00 cylinder	5.80
V2108 – 4.25 – 7.00/2.25 – 4.00 cylinder	7.51

Single Vision (Plus or Minus)	*Price Per Lens*
V2109 – 4.25 – 7.00/4.25 – 6.00 cylinder	7.67
V2110 – 4.75 – 7.00/over 6.00 cylinder	8.50
V2111 – 7.25 – 12.00/0.25 – 2.25 cylinder	8.21
V2112 – 7.25 – 12.00/2.25 – 4.00 cylinder	9.26
V2113 – 7.25 – 12.00/4.25 – 6.00 cylinder	12.50
V2114*– 7.25 – 12.00/over 6.00 cylinder	29.95

Bifocal Sphere (Plus or Minus)

Bifocal Sphere (Plus or Minus)	*Price Per Lens*
V2200 – Plano – 4.00	$6.75
V2201 – 4.25 – 7.00	7.69
V2202 – 7.25 – 12.00	7.62

Bifocal Spherocylinder (Plus or Minus)

Bifocal Spherocylinder (Plus or Minus) Cylinder	*Price Per Lens*
V2203 – Plano – 4.00/0.25 – 2.00 cylinder	$7.68
V2204 – Plano – 4.00/2.25 – 4.00 cylinder	7.79
V2205 – Plano – 4.00/4.25 – 6.00 cylinder	7.79
V2206 – Plano – 4.00/over 6.00 cylinder	7.55
V2207 – 4.25 – 7.00/0.25 – 2.00 cylinder	7.80
V2208 – 4.25 – 7.00/2.25 – 4.00 cylinder	7.95
V2209 – 4.25 – 7.00/4.25 – 6.00 cylinder	7.72
V2210 – 4.75– 7.00/over 6.00 cylinder	9.46
V2211 – 7.25 – 12.00/0.25 – 2.25 cylinder	10.05
V2212 – 7.25 – 12.00/2.25 – 4.00 cylinder	9.26
V2213 – 7.25 – 12.00/4.25 – 6.00 cylinder	8.01
V2214* – 7.25 – 12.00/over 6.00 cylinder	50.27
V2199 – Over plus or minus 12.00 diopters	22.08
V2700 – Balance lens	1.45

Other

Other	*Price Per Lens*
V2115 – Lenticular (Myodisc) * (stand alone)	31.70
V2121 – Lenticular lens, per lens, single * (stand alone)	9.00
V2299 – Executive Bifocals * (stand alone)	11.76
V2399 – Trifocals * (stand alone)	9.36
V2499 – Aspheric * (stand alone cost)	6.70
V2710 – Slab-off Prism * (stand alone)	30.00
V2715 – Prism Add ** (add-on)	1.00
V2718 – Press On Fresnell Prisms ** (add on)	15.00
V2745 – Tinted Lenses ** (add-on)	1.00
V2784 – Polycarbonate Lenses * (stand alone)	11.80

NOTE:

Procedure Code V2784 (Polycarbonate Lens) is a stand alone code and should not be billed in addition to another lens code for the same eye.

Lenses Requiring Prior Authorization from Medicaid Before Ordering

Lens	*Price per Lens*
V2744 – Photocromic ** (add-on cost)	$15.00
V2755 – UV 400 Coating ** (add-on cost)	3.00
V2781 - Progressives - CR-39 (effective July 1, 2002)	25.00

* Stand Alone Cost: This item is all-inclusive, billed with no other lens code.

** Add-on Cost: This item to be billed in addition to appropriate lens code.

Frames

NOTE:

Providers shall bill the price of the frame in this manual and not their usual and customary price for the frame.

Women's Frames- Providers should bill the price of the frame in this manual and not their usual and customary price for the frame

Frame	*Code Description*	*Price*
V2020	Hart Specialties J5631	9.95
V2020	CC 52 Zimco	8.65
V2020	CC 57 Zimco	9.65
V2020	CC 53 Zimco	8.65
V2020	J5602 Hart Specialties	8.65
V2020	Zimco S-310	7.65
V2020	Zimco Karen	9.65
V2020	Zimco S-304	8.65
V2020	Zimco S-302	8.95
V2020	Zimco Electra	8.95
V2020	Zimco S-313	7.95

Girls' Frames- Providers should bill the price of the frame in this manual and not their usual and customary price for the frame

Frame	*Code Description*	*Price*
V2020	Boulevard 4170	8.65
V2020	Pumpkin	8.69
V2020	Panda CCS	15.65
V2020	Curly Ltd. Edition	9.65
V2020	Modern Optical Gift	9.20
V2020	Europa L Cable	13.95

Men's Frames- Providers should bill the price of the frame in this manual and not their usual and customary price for the frame

Frame	*Code Description*	*Price*
V2020	Trenton	7.65
V2020	Atlantic	7.65
V2020	Manchester Limited Edition	12.65
V2020	Moscow	7.65
V2020	Leo #2	8.65
V2020	Star	7.65
V2020	Uptown	7.65

Frame	*Code Description*	*Price*
V2020	J5638	8.65
V2020	J5603	8.65
V2020	901 Detari/Europa	9.20
V2020	908 Detari/Europa	8.65
V2020	Zimco Blazer	8.95
V2020	Zimco Kennedy	5.95
V2020	Zimco S-305	7.95
V2020	Overvue Zimco	7.65
V2020	S-510	7.65

Boys' Frames- Providers should bill the price of the frame in this manual and not their usual and customary price for the frame

Frame	*Code Description*	*Price*
V2020	Chuckles	11.65
V2020	Pacific	7.65
V2020	Rae	7.65
V2020	CC 42	8.65
V2020	CC 37	8.65

Unisex Frames for Men, Women, Boys, Girls- Providers should bill the price of the frame in this manual and not their usual and customary price for the frame

Frame	*Code Description*	*Price*
V2020	Cambridge	7.65
V2020	LG 1050	7.95
V2020	S-502	7.65
V2020	Overlook Hart	6.35
V2020	Ontario Zimco	10.65
V2020	Gusto	8.65
V2020	Boulevard 4502 Hart	9.65
V2020	Boulevard 4508 Hart (may substitute Ellen - Phil Optiks)	9.65
V2020	S 301	8.95
V2020	Boulevard 4509 Hart	9.65
V2020	Kidco 6	9.65
V2020	J5616	8.65
V2020	J5606	8.65
V2020	Kidco 5	9.65
V2020	LTD 182	10.95
V2020	905 Detari/Europa	8.65
V2020	911 Detari/Europa	8.65
V2020	Zimco Chelsea	7.95
V2020	Zimco Monaco	6.65
V2020	CC61	8.95
V2020	S323	7.95
V2020	S324	7.95
V2020	S325	7.95
V2020	Mainstreet 415	9.20
V2020	911 Detari	8.65
V2020	Christy Zimco	7.65

Special Frame (Size, Type) Other Than Above- **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame**

Frame	*Code Description*	*Price*
V2025	Special Order Frames (***PA REQUIRED***)	$39.95

15.5.4 Place of Service Codes

The following place of service codes apply when filing claims for eye care services:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility

15.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances.

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

15.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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