INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Vision Services

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletin, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT2026155 – IHCP updates billing requirements for specific waiver services and specific vision services*

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7.0	Policies and procedures as of Sept. 1, 2023 Published: Jan. 4, 2024	Scheduled update: • Reorganized and edited text as needed for clarity • Added two drugs that require PA in the *Prior Authorization for Vision Services* section • Replaced IVR system reference with GABBY in the *Vision Benefit Limits* section • Clarified information and added note regarding MSRP or cost invoice in the *Frames* section • Updated note in the *Physician-Administered Ophthalmologic Drugs* section • Updated the *Fluocinolone Acetonide Intravitreal Implant (Retisert)* section	FSSA and Gainwell

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		• Added the *Fluocinolone Acetonide Intravitreal Implant (Yutiq)* section • Updated the *Voretigene Neparvovec-rzyl (Luxturna)* section	
7.1	Policies and procedures as of Sept. 1, 2023 Published: Sept. 24, 2026	Interim update: • Added note on title page pointing to *IHCP Bulletin BT2026155*	FSSA and Gainwell

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> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise member services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

Introduction

Vision services are provided to Indiana Health Coverage Programs (IHCP) members as described in this module, and subject to limits established for certain benefit plans. Ophthalmology services must be provided by an ophthalmologist or an optometrist within the scope of their licensure:

- Ophthalmologists are licensed medical physicians or osteopathic physicians with the ability and credentials to perform surgical procedures on the eye and related structures.
- Optometrists are licensed professionals trained to examine eyes and vision, prescribe and fit lenses, and diagnose and treat visual problems or impairment.

Other vision-related services, such as pharmaceutical services and surgeries, are covered services when determined to be medically necessary.

The IHCP also reimburses optometrists for diabetes self-management training and tobacco dependence counseling when the services are delivered and billed as described in the *Diabetes Self-Management Training Services* and *Behavioral Health Services* modules.

Prior Authorization for Vision Services

The IHCP does not require prior authorization (PA) for most vision care services. However, PA **is** required for the following services:

- Blepharoplasty for a significant obstructive vision problem
- Prosthetic device, except eyeglasses
- Reconstruction or plastic surgery
- Certain medications, including:
  - Fluocinolone acetonide intravitreal implant (Yutiq)
  - Fluocinolone acetonide intravitreal implant (Retisert)
  - Voretigene neparvovec-rzyl (Luxturna)

For general information about requesting PA, see the *Prior Authorization* module.

Vision Benefit Limits

Information about whether a member has reached certain benefit limits, including limits for vision services, is available through the Eligibility Verification System (EVS), which providers can access through any of the following methods:

- IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers
- Virtual assistant (GABBY) at 800-457-4584, option 2
- 270/271 Eligibility Benefit Inquiry and Response electronic transaction using approved vendor software

However, the EVS may not include all the information a provider needs, such as the dates on which the limits were exhausted. When additional benefit limit information is required, beyond what is available through the EVS, providers may submit an inquiry via the IHCP Portal to the Written Correspondence Unit.

For more information about using the EVS and written correspondence to check benefit limits, as well as requirements that must be met before billing members for services that exceed their benefit limits, see the *Member Eligibility and Benefit Coverage* module.

> *Note: Benefit limit information provided through the EVS and the Written Correspondence Unit is for fee-for-service (FFS) claims only. For managed care claims, contact the appropriate MCE for information about a member's service limits.*

Billing and Reimbursement for Vision Services

Providers must use the appropriate Current Procedural Terminology (CPT®[1]) codes or Healthcare Common Procedure Coding System (HCPCS) codes when submitting claims for vision services to the IHCP.

The IHCP reimburses opticians (specialty 190) and optometrists (specialty 180) only for services listed in their respective provider specialty code sets. Optician and optometrist code sets are available in *Vision Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

> *Note: All claims must reflect a date of service. The date of service is the date the specific services were actually supplied, dispensed or rendered to the patient. For example, when providing glasses for a member, the date of service would reflect the date the member received the glasses. This requirement is applicable to all IHCP-covered services.*

Eye Examinations

IHCP coverage for an initial and routine eye examination is limited to the following:

- For members under 21 years of age – One examination per 12-month period
- For members 21 years of age and older – One examination every two years

If medical necessity dictates more frequent examination or care, documentation of such medical necessity must be maintained in the provider's office and is subject to postpayment review and audit.

[1] *CPT copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

When billing eye examinations, providers should use the CPT code that best describes the examination. Providers may code examinations in which counseling and coordination of care are the dominant services with the appropriate evaluation and management (E/M) code, using the time factor associated with the code. Documentation in the patient's record must include the total time of the encounter and a synopsis of the counseling topics and coordination of care efforts. The eye examination may include the following services; providers should not bill for these services separately:

- Eye examination, including history
- Visual acuity determination
- External eye examination
- Biocular measurement
- Routine ophthalmoscopy
- Tonometry and gross visual field testing including color vision, depth perception or stereopsis

Diagnostic Services

See *Indiana Administrative Code 405 IAC 5-23-3* for a list of diagnostic services that can be provided, if medically necessary, in addition to the initial eye examination.

The IHCP reimburses provider specialty 180 – *Optometrists* for CPT code 95930 – *Visual evoked potential (VEP) testing central nervous system, checkerboard or flash* only when billed with one of the diagnosis codes listed for it in *Vision Services Codes* on the *Code Sets* page at in.gov/medicaid/providers.

Eyeglasses

The IHCP provides coverage for eyeglasses if minimum prescription criteria are met, with the following frequency limits:

- For members under 21 years of age – One pair of eyeglasses per 12-month period
- For members 21 years of age or older – One pair of eyeglasses every five years

The IHCP provides reimbursement for the initial or subsequent pair of eyeglasses only when at least one of the following minimum prescription criteria is met:

- A minimum initial prescription of (or, for a subsequent pair of glasses, a minimum change of):
  - For members 6 years of age to age 42 – 0.75 diopters in at least one eye
  - For members 42 years of age and older – 0.50 diopters in at least one eye
- An axis change of at least 15 degrees

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

The IHCP considers the following services bundled into the reimbursement for eyeglasses and not separately billable to the IHCP or the patient:

- Eyeglass cases
- Fitting of eyeglasses
- Neutralization of lenses
- Verification of prescription

Repair or Replacement of Eyeglasses

Repair or replacement covers the part of the eyeglasses that is broken or damaged. Members are not entitled to a new pair of eyeglasses if the lenses or frames can be repaired or replaced.

Repair

To bill for repair of eyeglasses before the member's established frequency limit has been reached, providers must use the modifier **U8**. Providers must keep the appropriate documentation on file in the member's record to substantiate the need to repair eyeglasses.

Replacement

Replacement of eyeglasses, or any part of the eyeglasses, must be for medical necessity. Providers must include documentation in the member's medical record to substantiate the need for replacement frames and/or lenses. In the case of eyeglasses that have been lost, stolen or broken beyond repair, the documentation must include a statement signed by the member detailing how the eyeglasses were lost, stolen or broken.

Providers should follow these billing guidelines:

- If a member needs replacement eyeglasses before the established frequency limits due to loss, theft or damage beyond repair, providers must use the modifier **U8** to bill for the replacement lenses or frames.
- If a member needs replacement eyeglasses before the established frequency limits due to a change in prescription as specified in *405 IAC 5-23-4(7)*, providers must use modifier **SC** when billing replacement lenses or frames.

Use of either modifier when billing for replacement of lenses or frames indicates that the appropriate documentation is on file in the member's record to substantiate the need to replace lenses and/or frames.

> *Note: Replacement of eyeglasses or any part of the eyeglasses (lenses or frames) represents the beginning of a new limit period for the replacement.*

Lenses

The prescription of lenses, when required, is included in CPT code 92015 – *Determination of refractive state.* This service includes specification of lens type (monofocal, bifocal or other), lens power, axis, prism, absorptive factor, impact resistance and other factors.

The IHCP does not provide coverage for all lenses. Noncovered services include:

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

In accordance with *405 IAC 5-23-4 (2),* the IHCP does cover tint numbers 1 and 2 (including rose A, pink 1, soft lite, cruxite and velvet lite), subject to medical necessity. The IHCP may reimburse for tints 1 and 2 only, billed with the following procedure code and modifiers:

- V2745 U1 – *Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens; rose 1 or 2, plastic*
- V2745 U2 – *Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens; rose 1 or 2, glass*

If a member chooses to upgrade to progressive lenses, transitional lenses, antireflective coating, or tint number other than 1 and 2, providers can bill the basic lens V code to the IHCP. Providers can bill the upgrade portion to the member only if they gave the member appropriate advance notification of noncoverage and if a separate procedure code for the service exists.

The IHCP covers safety lenses only for corneal lacerations and other severe intractable ocular or ocular adnexal disease.

Polycarbonate Lenses

The IHCP developed specific criteria for polycarbonate lenses to ensure that these lenses are used only for members with conditions that make additional ocular protection medically necessary. HCPCS code V2784 – *Lens, polycarbonate or equal, any index, per lens* is covered when a corrective lens is medically necessary and one or more of the following criteria is met:

- Member has carcinoma in one eye, and the healthy eye requires a corrective lens.
- Member has only one eye, and that eye requires a corrective lens.
- Member had eye surgery and still requires the use of a corrective lens.
- Member has retinal detachment or is postsurgery for retinal detachment and requires a lens to correct a refractive error of one or both eyes.
- Member has a cataract in one eye or is post-cataract-surgery, and requires a lens to correct a refractive error of one or both eyes.
- Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye.
- Member has other conditions for which the optometrist or ophthalmologist has deemed polycarbonate lenses to be medically necessary. These conditions must be such that one eye is affected by an intractable ocular condition, and the polycarbonate lens is being used to protect the remaining vision of the healthy eye.

In all these situations, one or both eyes must be affected by an intractable ocular condition. The IHCP covers the polycarbonate lens only to protect the remaining vision of the healthy eye when it is medically necessary to correct a refractive error. Patient charts must support medical necessity. The IHCP monitors use of these lenses in postpayment reviews.

Frames

The IHCP reimburses for frames including, but not limited to, plastic or metal frames. Providers that receive payment from the IHCP for frames may not bill the member for any additional cost above the IHCP reimbursement amount.

Providers should bill for frames using procedure code V2020 – *Frames, purchases*, which the IHCP reimburses at the maximum-fee amount indicated on the Professional Fee Schedule (accessible from the *IHCP Fee Schedules* page at in.gov/medicaid providers). The IHCP does not pay more than this amount for frames, except when medical necessity requires a more expensive frame. Situations where medical necessity for a more expensive frame may be indicated include, but are not limited to:

- Special frames to accommodate a facial deformity or anomaly
- Frames with special modifications, such as a ptosis crutch
- Frames for a member with an allergy to standard frame materials
- Frames for an infant or child requiring the prescription of special-size frames

When a more expensive frame is medically necessary, the claim should be billed with procedure code V2025 – *Deluxe frame.* All claims for V2025 must be accompanied by documentation supporting medical necessity. In addition, providers **must** submit a manufacturer's suggested retail price (MSRP) or cost invoice and charges for medically necessary deluxe frames. The IHCP reimburses medically necessary deluxe frames up to 75% of the MSRP or up to 120% of the cost invoice. Providers that receive payment from the IHCP for frames may not bill the member for any additional cost that is more than the IHCP reimbursement.

> *Note: Effective Jan. 7, 2024, the maximum age for an MSRP or cost invoice is two years from the date of service. Providers will be required to submit the most current MSRP or cost invoice that is not older than two years with claims for manually priced items.*

The IHCP does not cover any portion of a deluxe or fancy frame purchase, except when medically necessary. If a member chooses to upgrade to a deluxe frame without medical necessity, the IHCP considers the entire frame noncovered, and the provider may bill it to the member, if the provider gave proper advance notice of noncoverage to the member and the member signed it. In these situations, providers should submit only the claim for the lenses to the IHCP.

Contact Lenses

The IHCP covers contact lenses when they are medically necessary. The IHCP does not require documentation with the claim, but providers must maintain documentation in the patient's medical record for postpayment review. Examples of medically necessity for contact lenses include but are not limited to:

- Members with severe facial deformity who are physically unable to wear eyeglasses
- Members who have severe allergies to all frame materials

The prescription of contact lens includes the specification of optical and physical characteristics such as power, size, curvature, flexibility and gas permeability. Providers can bill for this service using the appropriate CPT code (92310 through 92317). These codes also include fitting contact lenses, instruction and training of the wearer, and incidental revision of the lenses during the training period; these services should not be billed separately. Providers should report follow-up of successfully fitted extended wear lenses as part of the general ophthalmologic service. If, after the successful fitting of extended-wear lenses, later modification or replacement is required, providers may bill these services using 92325 or 92326.

Orthoptic or Pleoptic Training, Vision Training, and Therapies

All vision training therapies are covered under CPT code 92065 – *Orthoptic and/or pleoptic training, with continuing medical direction and evaluation*. CPT code 92065 is limited to one unit or visit per day.

For IHCP coverage of this service, the medical record must be maintained to support medical necessity and the following criteria must be met:

- A physician or an optometrist must order all vision therapy services.
- The physician or optometrist must document, in the member's medical record, a diagnosis and treatment plan and the need for continued treatment.
- An optometrist, a physician or supervised staff that is certified or trained to provide these services can perform vision therapy services.
  - Staff trained or certified in vision training may perform orthoptic and pleoptic training *only* under the *direct supervision* of an optometrist or physician. Direct supervision requires the

supervising physician or optometrist must be physically available at the time and the place where the vision therapy services are rendered.

- *Only* the supervising optometrist or physician may document the treatment plan and reevaluations in the medical record.
- All documentation of directly supervised vision therapy services rendered by staff must be **cosigned** in the medical record by the supervising optometrist or physician.

These services are noncovered by Medicare. Therefore, for dually eligible members who have both Medicare and full Medicaid coverage, providers can bill these services directly to the IHCP on a professional claim (*CMS-1500* claim form, IHCP Portal professional claim or 837P electronic transaction) without first submitting the claim to Medicare.

Ophthalmologic Surgeries

Documentation must be maintained in the member's medical records to support medical necessity for all ophthalmologic surgeries. See the *Surgical Services* module for general information about billing and reimbursement for surgical services.

Intraocular Stents

The IHCP covers intraocular stents inserted in conjunction with cataract surgery. Any claim for an intraocular stent code must also include a cataract surgery code. For applicable procedure codes, see the *Cataract Surgery Codes That Allow for Reimbursement of Intraocular Stents and Intraocular Lenses* table in *Vision Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Intraocular Lenses

New technology intraocular lenses (NTIOLs) are intraocular lenses that the Centers for Medicare & Medicaid Services (CMS) has identified as being superior to other intraocular lenses of the same category because of a demonstrated decrease in postoperative complications. The IHCP covers NTIOLs only when billed in conjunction with a cataract surgery code. For applicable procedure codes, see the *Cataract Surgery Codes That Allow for Reimbursement of Intraocular Stents and Intraocular Lenses* table in *Vision Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Any facility reimbursed at an ASC rate should submit claims for surgical insertions of intraocular lenses using the physician's CPT code for the cataract surgery and the appropriate revenue code on an institutional claim (*UB-04* claim form, IHCP Portal institutional claim or 837I electronic transaction). The NTIOL claim must be submitted on a separate professional claim (*CMS-1500* claim form or electronic equivalent) using the facility's durable medical equipment (DME) National Provider Identifier (NPI).

Providers must submit an MSRP or cost invoice with procedure code C1780.

Corneal Tissue

Information about corneal tissue transplantation, corneal tissue acquisition and intrastromal corneal ring segments can be found in the *Surgical Services* module.

Vitrectomy

A vitrectomy is the removal of the vitreous humor when it is diseased or damaged. Diagnoses that may support medical necessity of vitrectomy as a sight-saving procedure include but are not limited to the following:

- Vitreal hemorrhage
- Retinal detachment
- Scarring or fibrosis of vitreous
- Proliferative retinopathy

Documentation must be maintained in the member's medical record. The claim will be processed as follows:

- If the vitrectomy is performed through the pars plana, the vitrectomy and the appropriate cataract extraction code will be paid according to the multiple-surgical-procedure payment guidelines.
- If the claim states "restorations of anterior chamber," the cataract extraction will be paid, and the vitrectomy is included in the procedure and will not be reimbursed separately.
- If an open-sky vitrectomy is performed with the cataract extraction, the vitrectomy and the cataract extraction will be paid according to the multiple surgical procedure payment guidelines.

Vitrectomy services billed with corneal transplant on the same eye will be denied if the service is to restore the anterior chamber. Vitrectomy through the pars plana or the open-sky technique with the corneal transplant is paid according to the guidelines for vitrectomy with cataract surgery. A pars plana vitrectomy and photocoagulation billed separately should be combined and coded appropriately.

Physician-Administered Ophthalmologic Drugs

The follow sections provide coverage criteria and billing guidance around certain physician-administered drugs for ophthalmologic purposes. For general information about physician-administered drugs, see the *Injections, Vaccines and Other Physician-Administered Drugs* module.

> *Note: Claims (and prior authorization, if applicable) for the drugs described in the following sections can only be processed through the member's **medical** benefit, not through the member's pharmacy benefit. For billing and reimbursement requirements related to drugs that are covered under the **pharmacy** benefit, see the Pharmacy Services module or contact the member's pharmacy benefit manager.*

Fluocinolone Acetonide Intravitreal Implant (Retisert)

The IHCP covers the fluocinolone acetonide intravitreal implant Retisert for the treatment of chronic posterior uveitis. Retisert should not be billed for diabetic macular edema.

Prior authorization is required. This agent may be considered medically necessary when all the following criteria (updated effective Dec. 9, 2022) are met:

- The member is 12 years of age or older.
- The member has a diagnosis of chronic noninfectious uveitis affecting the posterior segment of the eye.
- The member has previously tried and failed conventional treatments (including corticosteroid therapy, methotrexate, mycophenolate, azathioprine, cyclosporine, tacrolimus, cyclophosphamide, or adalimumab), or medical justification is provided for use of Retisert over these therapies.

HCPCS code J7311 – *Injection, fluocinolone acetonide, intravitreal implant (Retisert), 0.01 mg* is limited to one implant per date of service and must be billed with the appropriate National Drug Code (NDC).

Fluocinolone Acetonide Intravitreal Implant (Yutiq)

The IHCP covers the fluocinolone acetonide intravitreal implant Yutiq for the treatment of chronic posterior uveitis. Yutiq should not be billed for diabetic macular edema.

For dates of service on or after Dec. 9, 2022, prior authorization is required. This agent may be considered medically necessary when all the following criteria are met:

- The member is 18 years of age or older.
- The member has a diagnosis of chronic, noninfectious uveitis affecting the posterior segment of the eye.
- The member has previously tried and failed conventional treatments (including corticosteroid therapy, methotrexate, mycophenolate, azathioprine, cyclosporine, tacrolimus, cyclophosphamide, or adalimumab), or medical justification is provided for use over these therapies.

HCPCS code J7314 – *Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg* must be billed with the appropriate NDC.

Voretigene Neparvovec-rzyl (Luxturna)

The IHCP provides reimbursement for voretigene neparvovec-rzyl (Luxturna) for the treatment of inherited retinal dystrophies (IRD) caused by mutations in the retinal pigment epithelium-specific protein 65kDa (RPE65) gene.

Prior authorization is required. in members Luxturna is considered medically necessary when all the following criteria (updated effective Dec. 9, 2022) are met:

- The member is greater than 12 months of age.
- The member has a diagnosis of a confirmed biallelic RPE65 mutation-associated retinal dystrophy (for example, Leber's congenital amaurosis [LCA], retinitis pigmentosa [RP] or early-onset severe retinal dystrophy [EOSRD]).
- Genetic testing documents biallelic mutations of the RPE65 gene.
- The member has sufficient viable retinal cells, as determined by the treating physician.
- Luxturna treatment is prescribed and will be administered by an ophthalmologist or retinal surgeon with experience providing subretinal injections.
- The member has not previously received RPE65 gene therapy in the intended eye.
- The dose does not exceed 0.3 mL per eye (two vials total).

Luxturna is billed using HCPCS code J3398 – *Injection, voretigene neparvovec-rzyl, 1 billion vector genomes.* The code must be billed with the appropriate NDC.

When delivered in an inpatient setting, Luxturna can be reimbursed separately from the all-inclusive inpatient hospital diagnosis-related group (DRG) payment. The drug must be billed as a professional claim, separate from the inpatient claim.

Triamcinolone Acetonide

The IHCP provides coverage for ophthalmologic use of triamcinolone acetonide through the following HCPCS codes:

- J3299 – *Injection, triamcinolone acetonide, suprachoroidal (Xipere), 1 mg*
- J3300 – *Injection, triamcinolone acetonide, preservative free, 1 mg*
- J3301 – *Injection, triamcinolone acetonide, not otherwise specified, 10 mg*

These HCPCS codes must be billed with an appropriate NDC. IHCP reimbursement for J3300 is limited to 40 mg per date of service.

The IHCP recognizes that preservative-free triamcinolone acetonide (J3300 and J3299) is distributed in single-dose vials of 40 mg, and some wastage of the product may be unavoidable. Thus, IHCP providers may bill the entire 40 mg in cases in which less than 40 mg are injected in a single treatment session, and the balance of the product is discarded. Whenever unused preservative-free triamcinolone acetonide is billed, both the amount of the agent actually administered and the amount discarded are to be documented in the member's medical record.

If an E/M code is billed with the same date of service as office-administered therapy, the administration should not be billed separately. Reimbursement for the administration is included in the E/M code-allowed amount. Separate reimbursement is allowed when the administration is the only service provided and billed by the practitioner.