



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Vision Services

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Revision History

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1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: December 15, 2016	Scheduled update	FSSA and HPE
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2.0	Policies and procedures as of April 7, 2017 Published: October 26, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of August 1, 2018 Published: April 9, 2019	Scheduled update: <ul style="list-style-type: none"> • Reorganized and edited text as needed for clarity • Updated links to new IHCP website • Added relevant information from the <i>Medical Policy Manual</i> • Updated the initial note box with standard wording • Removed managed care information in the Introduction section • Removed the <i>Coverage and Restrictions for Vision Services</i> section, because the information was covered in other sections • Added IHCP provider specialty numbers in the Billing and Reimbursement for Vision Services section • Removed the <i>Vision Procedures Limited to One Unit</i> section • Clarified information in the Eye Examinations section (including that the benefit limits apply to both initial and routine exams) and removed the list of procedure codes • Clarified reimbursement criteria in the Eyeglasses section 	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> • Updated the Repair or Replacement of Eyeglasses section • Added information about providers not billing members for costs above IHCP reimbursement in the Frames section • Updated the Orthoptic or Pleoptic Training, Vision Training, and Therapies section • Added the Ophthalmologic Surgeries heading and introductory text, and updated the subsections as follows: <ul style="list-style-type: none"> – Replaced information in the Corneal Tissue subsection with a cross-reference to the <i>Surgical Services</i> module – Added the Vitrectomy subsection • Added the Physician-Administered Ophthalmological Drugs heading and introductory text, and updated the subsections as follows: <ul style="list-style-type: none"> – Added the Voretigene Neparvovec-rzyl (Luxturna) subsection – Added J3300 as a drug that could be billed for ophthalmological use and added NDC requirements in the Triamcinolone Acetonide subsection – Added PA requirements in the Fluocinolone Acetonide Intravitreal Implant (Retisert) subsection 	

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Note: The information in this module applies to services provided under the fee-for-service delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization requirements, billing procedures, and reimbursement methodologies. For services covered under the managed care delivery system, providers must contact the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member's MCE or refer to the MCE provider manual for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers.

For updates to the information in this module, see [IHCP Banner Pages and 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 limitations 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, surgeries, and diabetes self-management training, are covered services when determined to be medically necessary.

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
- Retisert

For general information about requesting PA, see the [Prior Authorization](#) module.

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* on 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 2 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.

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 in *Vision Services Codes* on the [Code Sets](#) page at in.gov/medicaid/providers.

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Eyeglasses

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

- 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 5 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 up 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.

Providers should follow these billing guidelines:

- To bill for repair of eyeglasses, providers must use the modifier **U8**.
- If a member needs replacement eyeglasses due to loss, theft, or damage beyond repair before the established frequency limitations, providers must use the modifier **U8** to bill for the replacement lenses or frames. Providers must include documentation in the member's medical record to substantiate the need for replacement frames or lenses. Documentation that eyeglasses have been lost, stolen, or broken beyond repair must include a signed statement by the member detailing how the eyeglasses were lost, stolen, or broken.
- If a member needs replacement eyeglasses due to a change in prescription before the established frequency limitations, as specified in 405 IAC 5-23-4(7), providers must use modifier **SC** when billing replacement lenses or frames.

Use of either replacement modifier indicates that the appropriate documentation is on file in the member's record to substantiate the need to replace lenses or frames. Replacement of eyeglasses must be for medical necessity.

Note: Replacement eyeglasses represent the beginning of a new limitation period.

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

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, which 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 should bill for frames using procedure code V2020. Providers that receive payment from the IHCP for frames may not bill the member for any additional cost above the IHCP reimbursement.

The maximum amount reimbursed for frames is \$20 per pair, 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

All claims for more expensive frames must be accompanied by documentation supporting medical necessity. Providers **must** submit a manufacturer's suggested retail price (MSRP) or cost invoice and charges for medically necessary deluxe frames with procedure code V2025. 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.

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 medical 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 ophthalmological 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, Provider Healthcare Portal [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. All intraocular stent codes must be billed with cataract surgery CPT codes 66982, 66983, 66984, or 66985.

For covered intraocular stent codes, see *Vision Services Codes* on the [Code Sets](#) page at in.gov/medicaid/providers. If more than one stent is required in the same eye, CPT code 0376T should be used for any additional stent.

Intraocular Lenses

New technology intraocular lenses (NTIOL) are IOLs that the Centers for Medicare & Medicaid Services (CMS) has identified as being superior to other IOLs of the same category, because of a demonstrated decrease in postoperative complications. The IHCP covers HCPCS code C1780 – *Lens, intraocular (new technology)*. Providers must submit an MSRP or cost invoice with procedure code C1780.

Any facility reimbursed at an ASC rate should submit claims for surgical insertions of IOLs using the physician's CPT code 66983, 66984, 66985, or 66986 and the appropriate revenue code on an institutional claim (*UB-04* claim form, 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).

Corneal Tissue

Information about corneal tissue transplantation, including corneal tissue acquisition, 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 Ophthalmological Drugs

The follow sections provide coverage criteria and billing guidance around certain physician-administered drugs for ophthalmological purposes.

Voretigene Neparvovec-rzyl (Luxturna)

Effective July 1, 2018, the IHCP provides reimbursement for HCPCS code C9032 – *Injection, voretigene neparvovec-rzyl, 1 billion vector genome* (Luxturna). The code must be billed with the appropriate National Drug Code (NDC).

Voretigene neparvovec-rzyl is proven and/or medically necessary for the treatment of inherited retinal dystrophies (IRD) caused by mutations in the retinal pigment epithelium-specific protein 65kDa (RPE65) gene in members when all the following criteria are met:

- The member is greater than 12 months of age.
- A diagnosis is made 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.
- Sufficient viable retinal cells, as determined by optical coherence tomography (OCT), confirm an area of retina within the posterior pole of >100 µm thickness.
- Luxturna is prescribed and will be administered by ophthalmologist or retinal surgeon with experience providing subretinal injections.
- The member has not previously received RPE65 gene therapy in intended eye.

This drug is carved out of managed care. The IHCP processes PA and claims for this procedure code through the fee-for-service (FFS) delivery system for all IHCP members, including those in Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise. In addition, this procedure code can be reimbursed separately from the all-inclusive inpatient hospital diagnosis-related group (DRG) payment when delivered in an inpatient setting. See the [Injections, Vaccines, and Other Physician-Administered Drugs](#) module for more information.

Triamcinolone Acetonide

The IHCP provides coverage for ophthalmologic use of triamcinolone acetonide (HCPCS code J3300 – *Injection, triamcinolone acetonide, preservative free, 1 mg* and J3301 – *Injection, triamcinolone acetonide, not otherwise specified, 10 mg*). Both J3300 and J3301 must be billed with an appropriate NDC.

The IHCP recognizes that triamcinolone acetonide, preservative free (J3300), 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. IHCP reimbursement for J3300 is limited to 40 mg per date of service.

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.

Fluocinolone Acetonide Intravitreal Implant (Retisert)

The IHCP covers HCPCS code J7311 – *Fluocinolone acetonide, intravitreal implant* (Retisert) for the treatment of chronic posterior uveitis. Retisert should not be billed for diabetic macular edema. This procedure is subject to PA with the following criteria:

- The member must have a diagnosis of chronic noninfectious posterior uveitis having lasted at least 1 year.
- The member must have previously failed conventional treatments, including periocular injections or corticosteroid therapy.

J7311 is limited to one unit per date of service and must be billed with the appropriate NDC.

Vision Benefit Limits

Certain benefit limits, including limits for vision services, are available through the Eligibility Verification System (EVS), which providers can access through any of the following methods:

- [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers
- Interactive Voice Response (IVR) system at 1-800-457-4584
- 270/271 electronic data interchange (EDI) transaction

For more information on the EVS options, see the [Provider Healthcare Portal](#), [Interactive Voice Response System](#), and [Electronic Data Interchange](#) modules.

Note: Benefit limit information provided through the EVS and the Written Correspondence Unit is for FFS claims only. For managed care members, contact the appropriate MCE for information about a member's vision service limitations.

Written Correspondence

Ophthalmology and optometric providers may not have the most current information available about services previously rendered to a member and paid by the IHCP, such as the dates the limits were exhausted. This situation can result in reduced reimbursement or no reimbursement for rendered services. Providers may submit secure correspondence through the Portal or write to the Written Correspondence Unit to inquire the date on which a particular member exceeded his or her service limitations for FFS claims. Providers should allow up to 4 business days for a response (plus delivery time, for inquiries sent by mail).

To assist analysts in researching the issue and providing a resolution, providers should clearly state the reason for the inquiry. The Written Correspondence Unit may contact the provider for additional information if needed. Providers should not send inquiries to resubmit claims previously rejected.

To submit an inquiry through the Portal, providers can create a secure correspondence message using the Coverage Inquiry category. For information about registering to use the Portal and submitting secure correspondence via the Portal, see the [Provider Healthcare Portal](#) module.

For inquiries sent via mail, providers should use the *Indiana Health Coverage Programs Inquiry Form*, available from the [Forms](#) page at in.gov/medicaid/providers, to ensure that complete information is sent in the inquiry. Mail written inquiries to the following address:

DXC Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

Billing a Member for Services that Exceed Benefit Limits

Providers may bill IHCP members for services exceeding the vision benefit limitations under the following circumstances:

- If the EVS indicates that the limitation has already been met, the provider should inform the member that the service will not be covered. If the member still wishes to receive the service, he or she may be asked to sign a waiver stating the service will not be covered because benefits have been exhausted and the member will be responsible for the charges.
- If the EVS does not indicate that benefits have been exhausted, the provider may ask the member or their guardian to attest in writing that they have not received Medicaid-covered glasses within the past 1 or 5 years (depending on their age). The member is informed that, if he or she is misrepresenting and the provider's claim is denied for exceeding benefit limitations, the member will be responsible for the charges.