

## APPENDIX G

# OPTOMETRY & OPTICIAN GUIDELINES

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**NOTE:** The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

## GENERAL CODING INFORMATION

### Use Of Modifiers For Identifying Specific Eye

- **Left and Right Eyes**
  - When using modifiers to identify the specific eye treated you should use one of the following immediately after the procedure code:
    - ✓ RT = Right
    - ✓ LT = Left
  - Each line should be coded separately using only one of the modifiers on each line.

- **Left, Right, Upper, and Lower Eyelids**

- When using modifiers to identify the specific eyelid treated you should use one of the following immediately after the procedure code:
  - ✓ E1 = Left upper eyelid
  - ✓ E2 = Left lower eyelid
  - ✓ E3 = Right upper eyelid
  - ✓ E4 = Right lower eyelid

- **Multiple Modifiers per Procedure Code**

- DO NOT use multiple modifiers on one line of service (i.e., RTE3; E1E2; LTE3; RTLT). Doing so will not allow your claim to process and will delay your payment.

<b>Eye Examinations (Excluding Boeing)</b>
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- **Routine Eye Examinations (Standard Benefit)**

One of the diagnoses from this list must be in the first position in box 21 for our system to recognize that the service is routine.

- **Diagnoses Considered Routine**

- ✓ **Disorders of refraction and accommodation**

367.0	Hypermetropia
367.1	Myopia
367.2	Astigmatism
367.20	Astigmatism, unspecified
367.21	Astigmatism, regular
367.32	Aniseikonia
367.4	Presbyopia
V72.0	Examination of eyes and vision

- **Procedure Codes**

- ✓ **Routine Eye Examination Procedure Codes:**

- 92002 Intermediate Eye Exam, New Patient

- 92004 Comprehensive Eye Exam, New Patient

- 92012 Intermediate Eye Exam, Established Patient

- 92014 Comprehensive Eye Exam, Established Patient

- **Reimbursement**

- The reimbursement will be based on the MAP for the 92012, not on the code billed.

- **Refraction 92015 with Routine Eye Examination**

- The refraction may be billed separately; however, the allowance for the combined charges (examination and refraction) will not exceed the maximum allowable payment for the routine eye examination.

- **Number of Routine Eye Examinations per Benefit Period**

- ✓ Most patient contracts limit the routine eye exam benefit to one per benefit year.

- ✓ Other contracts limit this benefit to one every two years.

- ✓ Please call Customer Service @ 800-432-0272, to ascertain the limit for a specific patient.

- **Contact lens examination, testing, fitting and 3 follow-up visits; contact checks**

- Please Note:** Please see Other Services/Contact Lens for Medical Conditions, further in this section if you are dispensing a lens for a medical condition.

- **Contact exam, testing, fitting and follow-up visits**

- ✓ If there is no vision hardware coverage these services are considered non-covered and are patient financial responsibility.

- ✓ You do not have to bill the contact exam, testing, fitting, follow-up visits to us, unless you want us to deny the service for benefit of notifying the patient. If there is no hardware coverage, then you may bill the patient at the time of service for the contact exam, testing, fitting, and follow-up visits.
- ✓ Also, “*Blue Shield Contact Exam, Testing, Fitting, Follow-Up Visits Patient Financial Responsibility*” Form is at the end of this section of the manual. It is suggested that you keep the signed form in the patient’s file for future reference if the patient questions whether they were informed.
- ✓ If billing for this service and lenses are not dispensed, you should code your claim as follows: 92310.

**Please Note:** Some providers may consider the AMA-CPT procedure codes of 92310, 92311, 92312, 92313, 92314, 92315, 92316, 92317, and 92325 to include the material. **BCBSKS does not include the material in these procedure codes.**

- ✓ We look at these codes as testing, fitting and follow-up only. Do not include your materials; material should be coded with the appropriate “V” HCPCS procedure codes.
- ✓ If billing for this service and lenses are dispensed, you should code your claim as follows:
  - 92310 for the professional portion      Vxxxx for the lenses dispensed
- ✓ If billing for a contact check, which is usually non-covered as stated under contact exam without hardware coverage, you should code your claim as follows and we will deny as patient financial responsibility if there is no vision correction benefit:
  - 92310 for the professional portion      Vxxxx for the lenses dispensed
- See Boeing Traditional for their guidelines.

- **Content of Service of Routine Eye Examination (other than Boeing)**

The following services are considered part of the routine eye exam and should not be billed separately:

- ✓ Preparation of patient record with routine demographic information.
- ✓ Analysis of power of present glasses, if any (manual or computerized automatic lens analyzer).
- ✓ Case history of symptoms, past medical/dental history, present medications and familial eye/vision problems, etc.
- ✓ Visual acuity testing at 20' (Snellen chart) and 14" to 16" (Near-point Snellen card), both unaided and present glasses, if any.
- ✓ Color vision testing with color plates, either monocularly or binocularly (Ishara Color Vision Plates).
- ✓ Tonometry, either by Schiottz indentation, MacKay-Marg Electronic Applanation, Goldmann Applanation or Non-Contact Methods (Tonometer).
- ✓ Objective measurement of static (distance) refractive error by either retinoscopy or computerized autorefractor (retinoscope or autorefractor). (This service can be broken out on your claim and we will combine the charge with the eye exam procedure code charge and only allow up to the MAP for the exam procedure code or your charge whichever is the lesser.)
- ✓ Blood pressure screening (sphygmomanometer).
- ✓ Cover test for gross muscle imbalances (occluder).
- ✓ Analysis of eye muscle movements, tracking and convergence (penlight).
- ✓ External ocular examination of lids and adnexae (penlight).
- ✓ Biomicroscopy of anterior segment-lid margins, corneas, iris, conjunctiva, estimation of anterior chamber depth, lens clarity, shallow vitreous (biomicroscope).
- ✓ Ophthalmoscopy, direct or indirect, from posterior poles, optic discs, maculas, and peripheral retinas (direct or indirect ophthalmoscope).
- ✓ Subjective coordination of testing for measurement of lateral or vertical imbalances as well as near focusing ability (phoropter, trial lens set and/or phorometer).
- ✓ Screening fundus photography (fundus camera).
- ✓ Screening for defects in central and/or peripheral field of vision (arc perimeter, tangent screen or computerized auto field analyzer).
- ✓ Ophthalmometry for measuring corneal curvature and for presence of scarring and/or keratoconus (ophthalmometer).

- ✓ Analysis of findings, consultation, determination of course of treatment and writing of prescription.
- ✓ Routine corneal topography.
- ✓ Other routine eye examination services.

• **Medical Eye Examinations**

▪ **Medical Diagnosis on Claim Form:**

A medical diagnosis must appear in the first position in Box 21 of the claim form.

▪ **Valid Procedure Codes for Medical Eye Examinations**

92002	99202	99212
92004	99203	99213
92012	99204	99214
92014	99205	99215
99201	99211	

▪ **Refraction 92015 with Medical Eye Examination**

This code may be billed separately, and reimbursement will be based on the appropriate year MAP for the code.

▪ **Medical Eye Examinations for Patients with Diabetes**

✓ **Diabetic Diagnosis Codes For All Policies:**

One of the following must be in the first diagnosis position in Box 21 of the claim form:

250.0—250.9	Diabetes mellitus
357.2	Polyneuropathy in diabetes
362.01	Background diabetic retinopathy
362.02	Proliferative diabetic retinopathy
362.03	Nonproliferative diabetic retinopathy
362.04	Mild nonproliferative diabetic retinopathy
362.05	Moderate nonproliferative diabetic retinopathy
362.06	Severe nonproliferative diabetic retinopathy
362.07	Diabetic macular edema
366.41	Diabetic cataract

- **Number of Medical Eye Examinations with Retinal Examination for Diabetic Patients per Benefit Period:**

One medical eye exam with retinal examination for diabetic patients per benefit period is allowed.

- **Medical Emergency Eye Care**

- **Medical Emergency Diagnosis on Claim Form:**

A medical emergency diagnosis must appear in the first position in Box 21 of the claim form.

- **Other Medical Services**

- **How to code your services for Medical Vision Correction Hardware**

Also see “DISPENSING” further in this section of the manual

- **Contact Lens for Medical Conditions**

Contracts that exclude coverage for contact lenses for routine vision correction may cover lenses for the treatment of a medical condition. If the diagnosis is on the approved diagnosis list you should apply the following:

- ✓ **Simple condition such as abrasion**

- Use 92002 through 92014 for the evaluation and management service.
- Use 92070 for the fitting and dispensing of the lens.

- ✓ **More complex conditions**

- Use E & M (99201 through 99215) or ophthalmology examination (92002 through 92014) procedure code for the exam.
- Use 92310- 92317 for the fitting of the lens.
- Use a V code for the dispensing of the lens.

✓ **Keratoconus**

➤ **Valid Diagnosis Codes**

Please use one of the following diagnoses in the first diagnosis position in Box 21 of the claim form when billing for care for this condition

- 371.60 Keratoconus, unspecified
- 371.61 Keratoconus, stable condition
- 371.62 Keratoconus, acute hydrops

➤ **Office Visit Procedure Codes for Keratoconus Patients**

See Medical Eye Examination and the codes listed there.

➤ **Contact Lens Procedure Code for Keratoconus Patient Care**

- ◆ Use 92310 - 92317 for the fitting of the lens.
- ◆ Use a V code for the dispensing of the lens.

➤ **Medical Records for Keratoconus Claims**

Medical records, in most cases, are not needed. You may send your claims in without them and if, for some reason, we need them we will request them.

➤ **Post Operative Care for Cataract Surgery**

BCBSKS will cover these services when performed by an optometrist if the surgeon does not bill the global fee for the surgery including pre and postoperative care. Following are the guidelines for billing:

- ◆ Use the appropriate procedure code for the surgery.
- ◆ Use modifier 55 with the procedure code for the surgery.
- ◆ The surgeon must use 54 modifier on his/her portion with the same procedure code. If he/she does not, the claim will be denied as already paid to another provider. (NOTE: Date of Service must reflect Date of Surgery)
- ◆ Units of service should equal 1 (Box 24G).
- ◆ Date Accepted/Relinquished and actual number of days should be in box 19 or the electronic narrative.
- ◆ Claim must show date of surgery (Box 24G).

**See Dispensing further in this section of the manual for cataract diagnoses and other pertinent guidelines for vision correction hardware.**

- **Glaucoma Screening**

- ✓ G0117 Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist
- ✓ G0118 Glaucoma screening for high-risk patients furnished under the direct supervision of an optometrist or ophthalmologist
- ✓ Both codes are considered content of the eye exam if performed on the same date
- ✓ If either procedure is performed by itself, it will be reviewed for possible coverage based on payment criteria for 92002.

- **Pachymetry**

- ✓ BCBSKS considers this service medically necessary, one per lifetime in relation to glaucoma evaluation, as an adjunct tool for those at high risk for glaucoma and/or corneal disorders.
- ✓ Pachymetry will not be allowed when scientifically demonstrated effect upon management of a disease is not documented. As an example, if the diagnosis of glaucoma is established the results of a pachymetry test would not be of value for clinical management.
- ✓ **Routine Glaucoma Screening using Pachymetry**  
The use of pachymetry for routine glaucoma screening is considered investigational and is a provider write-off unless a Policy Memo No. 1 Limited Patient Waiver is signed prior to the service. GA modifier should be used with code to indicate waiver on file.
  - Waiver for FEP – For FEP patients the waiver is only accepted for services considered not medically necessary. This means in the case of pachymetry used for routine glaucoma screening the service would

be a provider write-off even if a waiver were signed prior to the service being rendered.

✓ **Procedure Codes for Pachymetry**

- 76514 Diagnostic Ultrasound – Head and Neck – Corneal pachymetry, unilateral or bilateral (determination of corneal thickness)

✓ **Valid Diagnosis Codes for Non-Routine Pachymetry**

- Please use one of the following diagnoses in the first diagnosis position in Box 21 of the claim form when billing for care for this condition:
- High-risk glaucoma indicative diagnoses codes
- Corneal disorders

364.53	365.10	366.11	371.23
364.77	365.11	367.0	371.57
365.00	365.12	367.1	371.58
365.01	365.13	367.20	996.51
365.02	365.14	371.20	
365.03	365.20	371.21	
365.04	365.23	371.22	

▪ **Visual Fields**

- ✓ **Gross Visual Fields:** Considered content of service of the routine eye examination and should not be billed separately.
- ✓ **Visual Fields (92081, 92082, 92083) codes are unilateral or bilateral; which means units of service are not necessary and will not be recognized when processing claims:** When billing visual fields for a medical condition in addition to a routine or medical eye examination you must make sure that the line item of service points to the correct diagnosis for coverage to be considered.

- ✓ In Box 24E the number placed here must correspond to the position number of the medical diagnosis in Box 21 that supports the performance of the visual fields (the medical diagnosis that warrants the visual field being performed should be in the 1st position in Box 21, then the number 1 must be indicated for the line billing the visual fields in Box 24E).

**Example of diagnosis coding and line item indications:**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY						22. MEDICAID RESUBMISSION CODE								
1. /365.11						3. / _____								
2. /367.1						4. / _____								
23. PRIOR AUTHORIZATION NUMBER														
24.		A			B	C	D	E	F	G	H	I	J	K
DATES OF SERVICE		Place of Service			Type of Service	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT	EMG	COB	RESERVED FOR LOCAL USE	
From MM	DD	YY	MM	DD	To YY									
			02	15	09	11	92012	2						
			02	15	09	11	92082	1						

- **Fundus Photography**

- ✓ **Fundus Photography Screening**

This service will be denied as content of service of the eye examination when billed with a routine diagnosis.

- Do not use 92250 for fundus photography screenings. Screenings should not be billed separately.

- ✓ **Fundus Photography with Interpretation and Report 92250:**

This service will be considered for payment if the diagnosis is other than routine.

- If you are following a medical condition you may bill for this service using 92250 if the service includes interpretation and report. The report must be written and maintained in the patient's file.
    - This procedure code is unilateral and must have units of 002 if providing bilateral service.

- When 92250 for a medical condition in addition to a routine or medical eye examination you must make sure that the line item of service points to the correct diagnosis for coverage to be considered.
  - In Box 24E the number placed here must correspond to the position number of the medical diagnosis in Box 21 that supports the performance of the fundus photos (the medical diagnosis that warrants the fundus photos being performed should be in the 1st position in Box 21, then the number 1 must be indicated for the line billing the fundus photos in Box 24E).
- **Computerized Corneal Topography: 92025**  
Please see the medical policy for this procedure code at the link below:  
  
[Corneal Topography / Computer-Assisted Corneal Topography / Photokeratoscopy](#)
  - **Optomap**  
The guidelines for fundus photography, as previously outlined in this section, apply to Optomap or any similar equipment.
  - **Photodynamic Therapy**
    - ✓ This service should be coded with 67221
    - ✓ This service is considered for reimbursement for age related macular degeneration (AMD).
    - ✓ Services for other diagnoses are subject to medical review.
  - **Lacrimal Duct Implants**
    - ✓ **Temporary Implant                   A4262**
      - Type of service 9
      - Indicate three digit units of service
    - ✓ **Insertion of Implant               68761**
      - Type of service 2
      - Indicate three digit units of service

- ✓ **Permanent Implant           A4263**
  - Type of service 9
  - Indicate three digit units of service

- ✓ **Reimbursement**
  - Full MAP will be allowed for the plugs
  - Full MAP will be allowed for the first insertion
  - ½ MAP will be allowed for the second insertion

- **Ophthalmic Diagnostic Imaging:**

- ✓ **92132 – Scanning Computerized Ophthalmic Diagnostic Imaging with Interpretation and Report, unilateral or bilateral.**
  - This code is considered **Experimental and Investigational (E/I)**.
- ✓ **92133 – Scanning Computerized Ophthalmic Diagnostic Imaging, posterior segment with Interpretation and Report, unilateral or bilateral, optic nerve.**
- ✓ **92134 - Retina**
  - This service is covered for 365.00 through 365.9 Glaucoma
  - Units of 001 should be used if billing for bilateral or unilateral.
  - Other diagnoses must be submitted with modifier 22 and medical records. Claims without medical records will be denied.

- **Vision Therapy**

Most member policies do not cover this service. Please call the Benefit Information Department to determine if your patient has the coverage.

# Dispensing

- **Assignment of Benefits (pertains to Opticians only)**

BCBSKS does not offer CAP contracts to opticians, hearing aid dispensers, private duty registered nurses or private duty licensed practical nurses since there are so few patient contracts that cover their services.

Your patients cannot assign the payment of the benefits to you.

- **Materials**

The AMA-CPT procedure codes of 92310, 92311, 92312, 92313, 92314, 92315, 92316, 92317, and 92325 - 92326 include the material by AMA-CPT definition.

- **BCBSKS does not include the material in these procedure codes.**

- We look at these codes as testing, fitting and follow-up only. Do not include your materials; they should be coded with the appropriate "V" HCPCS procedure codes.

- **Coverage**

Most patients' contracts only cover lenses, frames or contact lenses when there has been cataract surgery or other medical conditions.

- **Medical and Routine Vision Correction**

- ✓ **Valid Procedure Codes**

- **Lenses, Frames, Contact Lenses**

Use current HCPCS codes and nomenclature listing for appropriate V-code for lenses, frames, and contact lenses for all claims submissions for dispensing. When using code V2781, please indicate whether it is for bifocals or trifocals, otherwise claim will be returned asking for clarification.

➤ **Dispensing**

Use AMA-CPT for the professional fee for dispensing for all claims submissions for dispensing. Do not include the charge for the material in this fee.

▪ **Eye Glass Lenses Guidelines**

- ✓ Use appropriate HCPCS “V” procedure codes, remembering to code the number of units per lens if more than one of the same power.

• **Coverage after Cataract Surgery**

Most BCBSKS contracts will cover vision correction hardware after there has been cataract surgery.

- Contact lenses are covered in place of glasses.

▪ **Diagnoses Codes for After Cataract Surgery**

379.31 Subluxation of lens

743.35 Congenital aphakia

V43.1 Organ or tissue replaced by other means (lens) pseudophakos

- An initial pair of eyeglasses, frames, and lenses (or contact lenses) is reimbursed only when surgery for age related, congenital, or traumatic cataracts has been performed to correct visual defects resulting from aphakia or pseudophakia. Reimbursement will only be made for the above diagnoses.
- When cataract surgery is performed on only one eye, reimbursement will still be made on the Frames, but only on the lens for the eye on which the surgery was performed.
- **These guidelines are not applicable to routine vision hardware benefits.**

• **Content of Service for Dispensing:**

- Shipping and handling
- Taxes
- Fitting
- Measuring
- Other dispensing services

- **Date of Service**

When dispensing frames and/or lenses the date of service must be the date the items were dispensed, not the date when they were ordered.

- **Deluxe Items**

See “Deluxe and Cosmetic Vision Correction Waiver” form at the end of this section.

- **S0500 Disposable Contacts**

- This code should not be used for any other type of lenses. Indicate number of lenses being dispensed in the units field of the claim form.

20 lenses = 020 units of service

6 lenses = 006 units of service

- On a claim attachment indicate the number of days, weeks, or months supply.
- Use modifier 22 when submitting any claim attachment.

- **V Codes for Non-Disposable Contacts**

You should use the appropriate V code(s) from the HCPCS Listing

- **V2710 Slab Off Prisms**

This service can be considered for separate reimbursement.

- Code one line of service with modifier 50 for bilateral procedure.

## Boeing

- **Boeing Routine Eye Examinations**

- **Boeing Procedure Codes and Diagnoses**

These products follow the same coding guidelines as regular BCBSKS claims.

- **Applicability of CAP Contract to Boeing Vision Exam**

When a provider is CAP contracting the CAP write-off amounts apply, whether the provider is Boeing Vision Exam (BVE) or not.

- **Content of Service for a Boeing Routine Eye Examination**

- ***Boeing Traditional:***

- The following services are considered part of the routine eye exam and should not be billed separately.

- ✓ Preparation of patient record with routine demographic information.
  - ✓ Analysis of power of present glasses, if any (manual or computerized automatic lens analyzer).
  - ✓ Case history of symptoms, past medical/dental history, present medications and familial eye/vision problems, etc.
  - ✓ Visual acuity testing at 20' (Snellen chart) and 14" to 16" (Near-point Snellen card), both unaided and present glasses, if any.
  - ✓ Color vision testing with color plates, either monocularly or binocularly (Ishara Color Vision Plates).
  - ✓ Tonometry, either by Schiottz indentation, MacKay-Marg Electronic Applanation, Goldmann Applanation or Non-Contact Methods (Tonometer).
  - ✓ Objective measurement of static (distance) refractive error by either retinoscopy or computerized autorefractor (retinoscope or autorefractor). (This service can be broken out on your claim and we will combine the charge with the eye exam procedure code charge and only allow up to the MAP for the exam procedure code or your charge whichever is the lesser.)
  - ✓ Blood pressure screening (sphygmomanometer).
  - ✓ Cover test for gross muscle imbalances (occluder).
  - ✓ Analysis of eye muscle movements, tracking and convergence (penlight).
  - ✓ External ocular examination of lids and adnexae (penlight).
  - ✓ Biomicroscopy of anterior segment-lid margins, corneas, iris, conjunctiva, estimation of anterior chamber depth, lens clarity, shallow vitreous (biomicroscope).
  - ✓ Ophthalmoscopy, direct or indirect, from posterior poles, optic discs, maculas, and peripheral retinas (direct or indirect ophthalmoscope).
  - ✓ Subjective refraction for correction of distance and ear refractive errors (phoropter or trial lens set).
  - ✓ Subjective coordination of testing for measurement of lateral or vertical imbalances as well as near focusing ability (phoropter, trial lens set and/or phorometer).
  - ✓ Screening fundus photography (fundus camera).
  - ✓ Screening for defects in central and/or peripheral field of vision (arc perimeter, tangent screen or computerized auto field analyzer).

- ✓ Ophthalmometry for measuring corneal curvature and for presence of scarring and/or keratoconus (ophthalmometer).
- ✓ Analysis of findings, consultation, determination of course of treatment and writing of prescription.
- ✓ Comprehensive biomicroscopy for contact lens evaluation.
- ✓ Keratometry for contact lens evaluation
- ✓ Fluorescein study for contact lens evaluation
- ✓ Anatomical measurements for contact lens evaluation.
- ✓ Fitting of diagnostic lenses.
- ✓ Follow-up visits
- ✓ Corneal photography to determine curvature of cornea for contact lenses.

**There are several levels of service involved with both of these procedures. It is the minimal level that is being considered content of service.**

- **Boeing Contact Lens Examination, Testing, Fitting and 3 Follow-Up Visits**

- ✓ These are considered content of service of the routine eye exam.
- ✓ If a provider is contracting with BVE, the contact exam, testing, fitting, and 3 follow-up visits are included in the routine vision exam (92002-92014).
- ✓ We prefer that you not separately bill this service.
- ✓ If for some reason you find it necessary to submit a charge for this service you should code it in the following manner:
- ✓ 92499 and include on claim attachment the following: "92499 = contact exam, testing, fitting and 3 follow up visits.
- ✓ Use modifier 22 when submitting any claim attachment.

- **Boeing Medical Eye Examinations**

Boeing processes these services under the medical portion of the member's contract. BCBSKS coding guidelines are used for Boeing medical eye examinations and are addressed earlier in the BCBSKS section of the manual.

- **Boeing Hardware**

- **Boeing Frames**

If you are contracting with the Boeing Vision Network Hardware, you have agreed to give a 15% discount off of your retail price, with the balance being patient responsibility.

- ✓ Do not take the 15% off your charge on the claim. We will do that for you.
- ✓ Boeing will allow \$70.00.
- ✓ Balances are patient responsibility.

- **Boeing Lenses**

The primary contractor has a schedule of fees that they will allow for lenses and contacts under the Boeing contract. These allowances may vary depending on the type of lens provided.

- ✓ The appropriate “V” procedure codes should be used.
- ✓ If billing for disposable lenses, modifier DL should be used with the “V” procedure code.
- ✓ Balances are patient responsibility.

**Blue Cross and Blue Shield of Kansas, Inc**  
 \*Independent Licensees of the Blue Cross and Blue Shield Association.  
**DELUXE and COSMETIC WAIVER for MEDICAL CONDITION**  
**Eyeglasses and Contact Lenses**  
*This form does not apply to Boeing patients.*

**The provider must document in the patient record the discussion with the patient regarding the following services.**

ITEM	CHARGE	ITEM	CHARGE
Deluxe Portion of Frame	\$	Metal Suspension	\$
Oversizing	\$	Engraving/Monogramming	\$
Beveling	\$	Photochromatic Tint	\$
Facets	\$	Tints (excluding Rose 1-2)	\$
Roll and Polish	\$	Disposable Sunglasses	\$
Frosting	\$	Scratch Resistant Coating	\$
Lip	\$	Disposable Lenses Portion	\$
Nylon String Mounting	\$	Contact Lens Tint	\$
Grooving	\$	Progressive Lenses Portion	\$
Notching	\$	Other (identify item)	\$
Drilling	\$	Other (identify item)	\$
Dispensing Deluxe/Cosmetic Portion	\$	Subtotal This Side	\$
Subtotal This Side	\$	Subtotal Left Side	\$
		<b>Grand Total</b>	\$

BCBSKS, Inc. benefits for vision correction services have some limitations. They will only reimburse for the standard appliance and if I choose to have deluxe or cosmetic service, I understand that I am financially responsible for those differences as outlined above. I realize that the standard item is available but it is my choice to have the more deluxe or cosmetic item(s). I also understand that the provider of the item(s) has the option to request this amount at the time the item is ordered, at the time it is delivered or at their normal billing time. The arrangements made to pay this amount are solely between myself and the provider of the item(s). I understand that BCBSKS, INC. has any involvement.

Patient Signature	Date
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Provider Please:

1. Keep original in patient's file.
2. Give copy to patient.
3. Send copy with claim.  
 Use V2799 NOC used for Deluxe/Cosmetic portion with one total sum for this on the claim form. On claim attachment indicate the following: V2799 = deluxe/cosmetic portion
4. Use V2020 for the standard frame portion.
5. Use appropriate dispensing, lens, and other covered services procedure codes from AMA-CPT and HCPCS for the remainder of the services or items.
6. Always use modifier 22 when submitting any claim attachment.

15-344 08/03

## REVISIONS

02/01/2011	<p>Changed revision date to “February 2011” from “June 2010.”</p> <p>Page G-13 –</p> <ul style="list-style-type: none"> <li>• Under bulleted code 92132, added a sub-bullet: <ul style="list-style-type: none"> <li>➢ This code is considered <b>Experimental and Investigational (E/I)</b>.</li> </ul> </li> <li>• Under bulleted code 92134, changed second sub-bullet to “001 units,” added “or unilateral,” and deleted “procedure.” Previous text read: <ul style="list-style-type: none"> <li>➢ Units of 002 should be used if billing for bilateral procedure.</li> </ul> </li> </ul> <p>Page G-15 –</p> <p>Under bullet “Lenses, Frames, Contact Lenses,” added the following verbiage: When using code V2781, please indicate whether it is for Bifocals or Trifocals, otherwise claim will be returned asking for clarification.</p>
06/13/2011	<p>Changed revision date to “June 2011” from “February 2011.”</p> <p>Page G-12 –</p> <p>Under bullet, “Computerized Corneal Topography: 92025,” removed the three sub-bullets (listed below), and added the link to the corresponding medical policy.</p> <ul style="list-style-type: none"> <li>✓ Use modifier 22 when submitting any claim attachment.</li> <li>✓ This service will be denied as content of service of the eye examination when billed with a routine diagnosis.</li> <li>✓ The service will be considered for reimbursement if billed with a medical diagnosis.</li> </ul>
07/14/2011	<p>Changed revision date to “July 2011” from “June 2011.”</p> <p>Page G-8 –</p> <p>Under “Post Operative Care for Cataract Surgery,” 4<sup>th</sup> bullet did read:</p> <ul style="list-style-type: none"> <li>◆ Units of service must reflect the number of post-op care days assumed. (Date of surgery counts as day #1.)</li> </ul> <p>Added a new 5<sup>th</sup> bullet.</p> <p>The final bullet on the page did read:</p> <ul style="list-style-type: none"> <li>◆ Claim must show date of service range (“From and To” in Box 24A) that equals the number of units indicated in Box 24G.</li> </ul>