



Vision and Ocular



**BlueCross
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**I. Preventive Eye Examinations
(Standard Benefit)**

When one of the diagnoses from the list below is submitted, the service is refractive and will be considered routine. Diagnoses must be submitted in loop 2300 HI01-2 electronically or in the primary position in Box 21 of the CMS 1500 claim form.

Diagnosis Codes Considered Routine

ICD-10	
H52.01	H52.221
H52.02	H52.222
H52.03	H52.223
H52.11	H52.32
H52.12	H52.4
H52.13	H52.6
H52.201	H52.7
H52.202	Z01.00
H52.203	Z01.01

**Procedure Codes for submission
of Preventive Eye Exams**

- 92002 Intermediate Eye Exam, New Patient
- 92004 Comprehensive Eye Exam, New Patient
- 92012 Intermediate Eye Exam, Established Patient
- 92014 Comprehensive Eye Exam, Established Patient

Refraction 92015

The routine refraction may be billed separately and allowed based on individual benefits. The allowance for the refraction will be content of service for a routine exam.

Note — For Federal Employee Program (FEP), if the 92015 is billed with a routine diagnosis, it will deny as non-covered (patient responsibility).

Benefit Period Limitations

Most patient contracts limit the member to one routine eye exam per benefit year. Check member eligibility for limitations.

II. Medical Eye Examinations

A medical diagnosis must be submitted in loop 2300 HI01-2 electronically or in the primary position in Box 21 of the CMS 1500 claim form.

**Valid Procedure Codes
for Medical Eye Examinations**

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

Refraction 92015

with Medical Eye Examination

Refractions may be billed and reimbursed separately from the medical eye examination when the eye exam/refraction is provided for a medical condition/diagnosis.

Accident/Medical Emergency

Diagnosis on Claim Form

An accident/medical emergency diagnosis must be submitted as the primary diagnosis in loop 2300 HI01-2 electronically or in the first position in Box 21 of the CMS 1500 claim form.

III. Content of Service

The following services are considered part of the 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 (retinoscopy or autorefractor).
- 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 near-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).

- External ocular photography
- 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.
- Determination of routine refractive state.

I. 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

Lenses, Frames, and Contacts

- Use appropriate V code and nomenclature listing for all claims.
- V2781 requires indication between bifocals or trifocals.
- When billing two lenses, use the appropriate code as one line item and indicate two units.
- Slab off prism: V2710 can be considered for separate reimbursement. When billing for a bilateral procedure, bill two line items with one unit each and an RT or LT modifier on each line.

Contact Lens Guidelines

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

When there is no coverage, it is unnecessary to bill the contact exam, testing, fitting, and/or follow-up visits to Blue Cross and Blue Shield of Kansas (BCBSKS) unless the provider wants the service to deny for the purpose of notifying the patient. The patient may be

billed at the time of service for the contact exam, testing, fitting, and/or follow-up visits.

Contact Lens for Medical Conditions

Contracts that exclude benefits for contact lenses related to routine vision correction may provide benefits for the treatment of a medical condition.

Fitting and supply of contacts:

- If billing for a contact lens fitting and lenses are not dispensed, providers should code claims with 92310-92326. BCBSKS does not include the reimbursement for lenses in these procedure codes.
- If billing for a contact lens fitting and lenses are dispensed, providers should code claims with 92310 for the professional portion and the proper V code for the lenses dispensed.
- Use 92071 for the fitting of the bandage lens. The cost of code 99070 (bandage lens) is included in the reimbursement of service when billed with 92071.
- Use code 92326 for the fitting of a replacement lens.
- Use the appropriate V code for non-disposable contacts.

II. Disposable Contacts

S0500 should only be used for disposable contacts, in box 24D of the CMS 1500 claim form or electronically in loop and segment 2400 and SV101-1. Indicate the number of lenses being dispensed as units for the service, using a three-digit number (20 lenses should be 020; six lenses should be 006).

The claim should indicate the number of days, weeks, or months supply in box 24G of the 1500 claim form or electronically in loop and segment 2400 and SV103.

III. Date of Service

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

IV. Charges Considered Content of Service

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

I. Keratoconus

- **Standard soft contacts** are not allowed for the management of keratoconus. They are considered non-covered since the soft contact lens used for this diagnosis is to improve vision, not to alter the progression of the disease.
- **Contact lenses** that are prescribed to diminish the progression of the disease and NOT to correct a vision problem will be allowed based on benefits.
- **Diagnosis codes for Keratoconus**

ICD-10	
H18.601	H18.613
H18.602	H18.621
H18.603	H18.622
H18.611	H18.623
H18.612	

II. Glaucoma Screening

- **G0117** — Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist.
- **G0117** is considered content of the eye exam if performed on the same date.
- **If G0117** is performed by itself, it will be allowed based on patient benefits.

III. Pachymetry

Pachymetry generally is medically necessary once in a lifetime. See [medical policy](#) at the BCBSKS website.

IV. Fundus Photography

For coverage guidelines for Fundus Photography (CPT code 92250), see [medical policy](#) at the BCBSKS website.

V. External Photos

CPT code 92285 is considered content of service.

VI. Visual Fields

- **Gross Visual Fields** are considered content of service of a routine eye exam and should not be billed separately.
- **Visual Fields codes** (92081, 92082, 92083) are unilateral or bilateral, which means units of service should equal one.
- **When billing Visual Fields** for a medical condition in addition to a routine or medical eye exam, the line item of service must point to the correct diagnosis for coverage to be considered.

VII. Blepharoplasty and Blepharoptosis

Prior authorization is highly recommended. The [Predetermination Request form](#) can be found at the BCBSKS website.

VIII. Optical Coherence Tomography (OCT) of the Anterior Eye Segment

Code 92132 is considered experimental/investigational. See [medical policy](#) at the BCBSKS website.

IX. Lasik

CPT codes 65760 and S0800 will be allowed for diagnosis of anisometropia. See [medical policy](#) at the BCBSKS website.

X. Computerized Corneal Topography

CPT code 92025 is considered experimental and investigational if diagnosis is not listed within the [medical policy](#) (at the BCBSKS website).

XI. Photodynamic Therapy

This service should be coded with 67221 or 67225 plus the appropriate injection code. See [medical policy](#) at the BCBSKS website.

XII. Ophthalmic Diagnostic Imaging

CPT codes 92133, 92134, 92227, and 92228. See [medical policy](#) for Scanning Computerized Ophthalmic Diagnostic Imaging Devices at the BCBSKS website.

XIII. Cataract Surgery

Cataract surgery is a covered benefit. If the surgeon does not bill the global fee for the surgery, CPT modifiers 54, 55, and 56 need to be used. Billing guidelines are as follows:

- Use the appropriate procedure code for the surgery. If only providing surgical care, append the surgery code with modifier 54 — Surgical Care Only.
- Use modifier 55 — Postoperative Management Only with the procedure code for the surgery to indicate postoperative period being assumed. The Date Assumed/Relinquished Care is submitted in Loop 2300 DTP electronically or Box 19 of the CMS 1500 paper claim along with the actual number of days being billed for the postoperative care.
- Claims must show Date of Surgery submitted in loop 2300 DTP electronically or Box 24A of the CMS 1500 paper claim.
- Units should equal 1 submitted in loop 2400 SV104 electronically or Box 24G of the CMS 1500 paper claim.

- All claims related to cataract surgery need to have surgery date and the same surgery procedure code.
- When billing both 54 and 55 modifiers, each should be listed on separate line items. The surgeon must use modifier 54 with the same procedure code. If the surgeon does not, the claim will be denied as already paid to another provider. Date Assumed/ Relinquished Care is submitted in loop 2300 DTP electronically or Box 19 along with the actual number of days being billed for the postoperative care.

lens for the eye on which the surgery was performed.

- Reimbursement is for standard lens allowance only. If member selects deluxe items, the standard lens allowance will be allowed and the balance will be patient responsibility.

Coverage after Cataract Surgery

Post-Cataract Surgery Diagnosis

Codes

ICD-10	
H27.01	Q12.3
H27.02	Z96.1
H27.03	

- 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.
- When cataract surgery is performed on only one eye, reimbursement still will be made on the frames but only on the

Annual eye exams are an important part of anyone's overall health routine, and they play a key role in ensuring a child's vision and academic development.

BlueCare plans include pediatric vision coverage for those important exams, eyeglasses and other benefits.

Below is a summary of the pediatric vision services offered to members up to age 19:

I. Eye Exams

- **Basic exams** are covered as needed when provided by ophthalmologists and optometrists.
- **Two exams** per month to detect and/or follow medical conditions.
- **As needed** up to one year following cataract surgery.

II. Eyeglasses (standard frames)

- **Frames** must include a one-year warranty.
- **Up to three** pairs of frames per 365 days.
- **One pair** of frames and lenses per date of service.
- **Up to three** sets of lenses per 365 days.
- **Eyeglasses** provided for post-cataract surgery within one year of surgery.
- **Only standard** frames are covered.

III. Contact Lenses

Contact lenses require prior authorization. Contact lens fitting is allowed once per lifetime when contacts are first prescribed and fitted. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted. Contact lenses and replacements are covered for monocular aphakia and bullous keratopathy.

IV. Blepharoplasty and Blepharoptosis

Surgery for the correction of eyelid defects requires prior authorization. The [Predetermination Request form](#) can be found at the BCBSKS website.

- Vision services are subject to applicable deductible, coinsurance or annual out-of-pocket maximum.

V. Exclusions

Although this is not a complete list, pediatric vision coverage excludes items such as LASIK surgery, sunglasses, safety glasses, athletic glasses, backup eyeglasses and contact lenses for cosmetic purposes. Pediatric vision coverage excludes sunglasses, transitional lenses, tints (including photochromatic), progressive lenses, safety glasses, athletic glasses, backup eyeglasses, polycarbonate lenses for convenience or cosmetic reasons, contact lenses for athletic participation, contact

sunglasses, colored or tinted of any kind,
contact lenses for cosmetic purposes and
eyeglass fitting fees.

I. Left and Right Eyes

Modifiers RT for right eye, LT for left eye or 50 (bilateral) can be used to identify the specific eye(s) treated. For example:

Modifiers	Units
50	001
RT LT	002
RT	001
LT	001

II. Left, Right, Upper, and Lower Eyelids

To identify the specific eyelid treated, use one of the following modifiers after the procedure code:

- E1 for left upper
- E2 for left lower
- E3 for right upper
- E4 for right lower

III. Waiver of Liability

BCBSKS offers a form called [Limited Patient Waiver](#) that should be used for situations involving medical necessity denials, utilization denials, patient demanded services, and procedures BCBSKS considers to be experimental/investigational.

When a provider is aware or suspects that a service may fall under one of those categories, a conversation is expected to

occur before the provision of the service.

This gives the patient the option of determining if they want to assume the financial responsibility for the service.

Once the waiver is signed by the patient, the document becomes a part of their medical record. The provider can then communicate this process by adding modifier GA to the specific procedure code for which the waiver was obtained.

[CMS 1500 Claim Form Tutorial](#)

[Professional Provider Manual](#)

Revisions

06/01/2018	Redesigned manual.
06/01/2018	Page 5 – Updated Refraction 92015 with Medical Eye Examination information.
06/01/2018	Page 8 – Updated Disposable Contacts information.
01/01/2019	Page 4 – Added code H52.6 to Diagnosis Codes Considered Routine.
	Page 11 – Added verbiage for reimbursement for standard lens.
	Page 12 – Added verbiage to Pediatric Vision Coverage under BlueCare Plans.



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