2026 Manual

Vision and Ocular

BlueCross BlueShield Kansas

bcbsks.com

Table of Contents

Eye Examinations

I. Eye Examinations

All eye exams are subject to member benefits.

II. 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.

If Box 10a, b **or** c, is marked "yes" another date related to the patient's condition or treatment is needed. Enter the date in a six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format. If Box 10a, b **or** c are marked "yes," Qualifier 439 must be reported in box 15 along with the date of the accident. (Loop 2300, DTP01 for qualifier and Loop 2300 DTP03 for date of accident for electronic claims).

III. Refraction 92015

The contracting provider agrees to submit claims to Blue Cross and Blue Shield of Kansas (BCBSKS) for covered services (excluding "self-pay" requests made by the patient as defined within the Health Information Technology for Economic and Clinical Health (HITECH) Act, Section 13405(a)) rendered to members and to look to BCBSKS for payment except for amounts identified as patient responsibility: copays, coinsurance, deductible, indemnified payment balances and non-covered amounts. **Services determined to be <u>content to another service</u> cannot be billed to the member and are a provider write-off.** Please refer to Policy Memo 1, Section X and XIV for more information.

- Refraction may be billed and reimbursed concurrently with an examination when the exam/refraction is provided for a medical condition.
- If a refraction (92015) is billed with an eye exam in absence of a medical condition/diagnosis, it will deny Content of Service to the exam.

  NOTE – For Federal Employee Program (FEP), if the 92015 is billed with a routine diagnosis, it will deny as non-covered (patient responsibility).
- Billing an exam with disorders of refraction and accommodation or a preventive diagnosis on the same date of service as a medical diagnosis for a refraction is not a typical scenario. This billing practice may be an audit red flag.

IV. 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 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 Schiotz 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 (phoroptor or trial lens set).
- Subjective coordination of testing for measurement of lateral or vertical imbalances as well as near-focusing ability (phoroptor, 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.

Hardware Coverage and Dispensing

I. Coverage

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

Vision Correction: *Lenses, Frames and Contacts*

- Use appropriate HCPC code and nomenclature listing for all claims.
- HCPC V2781 requires indication between bifocals or trifocals by reporting appropriate HCPC code for the lenses.
- When billing two lenses, use the appropriate code as one line item and indicate two units.
- Slab off prism: HCPC 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

Contact lens coverage is subject to member benefits. 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 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.

If coverage exists, reimbursement for contacts is per box and not per lens.

Contact Lens for Medical Conditions

Contracts that exclude benefits for contact lenses related to 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 (two boxes should be reported as 002; one box should be reported as 001).

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. Deluxe Services

Deluxe services should be billed as follows:

- Bill one line for the standard frame or lens (example: V2020) with your standard fee.
- Bill one line for the deluxe frame or lens (example: V2025) with the difference between your standard option and the deluxe option.
- A waiver for the deluxe service must be signed by the member prior to services being rendered. If a waiver is on file, any amounts over the MAP for a standard frame/lens will not be covered and will be the patient’s responsibility.
- GA is added to line #2 indicating a valid waiver is on file for the "deluxe" item.
- Records are required, so the claim will need to be submitted via paper with attached information including cost, description of deluxe item, invoice, etc.

V. Charges Considered Content of Service for Hardware

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

Additional Guidelines

I. Avastin Coding

When billing ophthalmic Avastin, report the appropriate HCPC code (e.g. J3490: unclassified drug or J3590: unclassified biologic).

For paper claims, report the name of the drug, dosage and NDC# in box 19 of the 1500 form.

Electronic claims, require the following information:

- Report qualifier “N4” in 2410 LIN02
- Report NDC# in 2410 LIN03
- Report dosage (National Drug Unit Count) in 2410 CTP04
- Units of measure ((UN=Unit, ml=, me=milligram, G= gram, F2=international unit) in 2410 CTP05-1
- Report “ADD” in 2400 NTE01
- Report name of drug in 2400 NTE02

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

- **Confrontational Visual Fields** are considered content of service of an 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.
- **Visual Field codes billed alone** (without exam) will be subject to member copay.

VII. Blepharoplasty and Blepharoptosis

Predetermination is highly recommended. The Predetermination Request form can be found on the BCBSKS website.

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

See medical policy on the BCBSKS website.

IX. Lasik

CPT codes 65760 and S0800 will be allowed for diagnosis of anisometropia.

X. Computerized Corneal Topography

See 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 on the BCBSKS website.

XII. Ophthalmic Diagnostic Imaging

CPT codes 92133 and 92134. See medical policy for Scanning Computerized Ophthalmic Diagnostic Imaging Devices on 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.
  If using 55 modifier, Box 15 must include Qualifier 090 with the date care was assumed.

Hardware Coverage After Cataract Surgery

Post-Cataract Surgery Diagnosis Codes

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

- 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 lens for the eye on which the surgery was performed.
- Reimbursement is for standard lens allowance only. If a member selects deluxe items, the standard lens allowance will be allowed, and the balance will be the patient's responsibility.
- State of Kansas members: There will be no coverage for hardware or contact lenses (with the exception of *intraocular lenses) under medical regardless of the medical diagnosis.

*Reimbursement is only allowed for a standard intraocular lens. If a deluxe intraocular lens (e.g., Restor) is selected, any amounts over the MAP for a standard lens will not be

covered and will be the patient's responsibility. A waiver for the deluxe service must be signed by the member prior to services being rendered. If a waiver is on file, any amounts over the MAP for a standard lens will not be covered and will be the patient's responsibility.

- See page 11 for deluxe services billing instruction.

Pediatric Vision Coverage under ACA Products

I. Pediatric Vision Coverage

Pediatric vision coverage under ACA products (BlueCare) is offered to members up to age 19. BlueCare plans include pediatric vision exams, eyeglasses, etc. You can verify member pediatric vision benefits through normal channels, i.e. Availity Essentials.

Claims Filing Guidelines

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. Additional Information/Education

CMS 1500 Claim Form Tutorial

Professional Provider Manual

Insurance Workshops

Limited Patient Waiver

Additional information and education can be found on www.bcbsks.com, under the Professional Provider tab.

Revisions

06/01/2018	Redesigned manual.
	Page 5 – Updated Refraction 92015 with Medical Eye Examination information
	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
01/01/2020	Page 5 – Updated Accident/Medical Emergency Diagnosis on Claim verbiage to reflect current practices
	Page 11 – Updated Cataract Surgery verbiage to reflect current practices
	Page 12 – Moved paragraph to intro to relate to entire section
01/31/2020	Page 9 – Removed Keratoconus verbiage
	Page 10 – Updated Optical Coherence Tomography (OCT) of the Anterior Eye Segment verbiage to reflect current practices
01/01/2021	Page 5 – Removed Refraction 92015 verbiage
	Page 6 – Updated Accident/Medical Emergency Diagnosis on Claim Form verbiage to reflect current practices
	Page 6 – Added new section, Refraction 92015
	Page 6 – Added verbiage to Content of Service
	Page 8 – Updated Coverage verbiage to reflect current practices
	Page 10 – Updated wording about Visual Field testing to reflect current practices
	Page 11 – Updated wording under Cataract Surgery to reflect current practices
	Page 13 – Added verbiage to Eyeglasses (standard frames)
	Page 16 – Added section, Documentation Requirements/Medical Records
	Page 19 – Added section, Additional Information/Education
	Page 20 – Added Limited Patient Waiver
05/24/2021	Page 10 – Updated wording about Visual Fields to reflect current practices
01/01/2022	Page 5 – Clarified wording about refractions
	Page 10 – Added Avastin Coding section
	Page 11 – Added information regarding Visual Fields and Visual Field codes billed alone
03/16/2022	Page 10 – Updated Avastin Coding Section for consistency across payers
01/01/2023	Page 4 – Added Coverage Clarification Section

	Page 15 – Updated Hardware Coverage After Cataract Surgery section, added last two bullets
	Page 16 – Updated title of Pediatric Vision Coverage under ACA Products
	Page 16 – Added deluxe information under section II. Eyeglasses (Standard Frames)
	Page 18 – Added deluxe information under Waiver of Liability section
02/2023	Page 6 – Updated all references of “preventive” to “routine” throughout for consistency in the “Routine Eye Examinations (Standard Benefit)” section, previous “Preventive Eye Examinations (Standard Benefit)” section
	Page 7 – Updated any reference to preventive to routine for consistency
	Page 12 – Updated Visual Fields section to reflect current billing practices
01/01/2024	Page 4 – Added chapter I. Important contact information
	Page 6 – Updated section I to reflect current benefit information for eye exams
	Page 7 – Updated section III to add clarification in billing refractions
	Page 8 – Updated section IV to remove last two bullets
	Page 10 – updated section I to reflect current practices
	Page 11 – updated dispensing section II to clarify coverage of lenses
	Page 11 – Added section IV on deluxe services, changing section numbers after by one in this chapter
	Page 13 – Updated section VI to reflect current visual field practices
	Page 13 – removed medical policy info beneath section IX
	Page 13 – updated section X to current practices
	Page 15 – removed deluxe services and moved to page 11
	Page 16 – added last bullet under section II
02/05/2024	Page 17 – Updated Pediatric vision section to refer to resources for member benefit confirmation
01/01/2025	Page 4 – Updated Important Contact Information section to reflect current information
	Page 7 – Added intro paragraph to section III. Refraction
	Page 11 – Updated section II. Disposable Contacts
	Page 14 – Updated section VII. Blepharoplasty and Blepharoptosis to include correct terminology
01/01/2026	Removed links throughout
	Page 4 – Removed Important Contact Information section
	Page 6 – Removed Coverage Clarification section
	Page 8 – Removed waiver information from Refraction section
	Page 9 – Updated Content of Service section for clarity

	Page 12 – Added “for Hardware” on Charges Considered Content of Service section for clarity
	Page 19 – Removed Waiver of Liability section
	Page 20 – Removed Documentation Requirements/Medical Records section

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