Vision Services Payment Policy

Policy

The Plan entered into an agreement with EyeMed Vision Care (EyeMed) to manage the Plan's vision and eyewear benefits effective July 1, 2012.

Vision center and/or optometry services:
In order to continue to service Plan members after July 1, 2012, providers need to be participating in the EyeMed Vision Care network. Call the EyeMed Provider Relations line at 1-888-581-3648 to initiate discussions with them regarding network participation.

Ophthalmology services:
In order to continue to provide routine vision care to Plan members, ophthalmologists must be credentialed through EyeMed. All routine vision care claims must be submitted to EyeMed. All medical claims should continue to be submitted to the Plan.

Reimbursement

Diagnostic eye exams:
The Plan will reimburse ophthalmologists for diagnostic eye exams when billed with the appropriate CPT codes, i.e., 92002-92014, and a non-routine diagnosis code.

Refraction:
For members enrolled through MassHealth and for members enrolled in the Plan's NaviCare® program, the Plan will reimburse refraction code 92015 regardless of diagnosis.

For members enrolled through Fallon Medicare Plus, the Plan does not separately reimburse for determination of refractive state (92015) when billed with a routine eye care diagnosis, as it is considered included in the routine eye exam (92002, 92004, 92012, 92014).

NaviCare: For members enrolled in the NaviCare program, the Plan will cover routine vision exams including refractions (code 92015) and fittings and adjustments of glasses. Claims for routine services should be billed directly to Eyemed.

Additionally, the Plan will cover up to $240 for contact lenses and/or one set of glasses per year. Items must be purchased from an EyeMed network provider. The following exclusions apply:

- Store promotions or coupons
- The one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery
- Two pairs of glasses in lieu of bifocals
- Non-prescription lenses and/or contact lenses
- Non-prescription sunglasses

All other covered medical vision services, including glaucoma screenings or diabetic retinopathy screenings, will be reimbursed by Fallon directly in accordance with the Navicare Evidence of Coverage and the provider's contract with Fallon Health.

Fallon Medicare Plus: For members enrolled in Fallon Medicare Plus, the plan will cover routine vision exams and fittings and adjustments of glasses. Claims for routine services should be billed directly to Eyemed.

Additionally, the Plan will cover up to $150 for contact lenses and/or one set of glasses per year. Items must be purchased from an EyeMed network provider. The following exclusions apply:

- Store promotions or coupons
- The one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery
- Two pairs of glasses in lieu of bifocals
- Non-prescription lenses and/or contact lenses

- Non-prescription sunglasses

All other covered medical vision services, including glaucoma screenings or diabetic retinopathy screenings, will be reimbursed by Fallon directly in accordance with the Fallon Medicare Pus Evidence of Coverage and the provider's contract with Fallon Health.

For all members, the Plan will reimburse ophthalmologists for refraction following cataract surgery only. Providers should submit a claim for refraction (92015) utilizing an appropriate ICD-10-CM code(s), such as Z98.41 (Cataract extraction status, right eye) or Z98.42 (Cataract extraction status, left eye) to the Plan.

Contact lens fittings for routine vision correction, such as nearsightedness or farsightedness (92310 and 92314) are not covered.

Note: All Optometry claims (routine and medical) should be submitted to EyeMed. All medical Ophthalmology claims should be sent to Fallon directly and Ophthalmology claims for routine services only should be submitted to EyeMed.

Referral/notification/prior authorization requirements

Most Plan members may self-refer for routine eye exams. PCP referral is required for diagnostic eye exams, unless otherwise specified in the member's Evidence of Coverage.

Fallon Health Weinberg Managed Long Term Care and PACE programs are based on member care coordination; therefore, we encourage referring providers to contact the member's designated care team if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Procedure Codes for Eye Exams

The following CPT codes (92002, 92004, 92012 and 92014) should be used for routine eye exams and medical eye exams.

Procedure code	Description
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92012	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, exstablished patient
92014	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits

Billing Medical Eye Exams

Claims for medical eye exams should be submitted to Fallon Health (including claims for refraction when performed).

Billing Routine Eye Exams

Claims for routine eye exams should be submitted to EyeMed. Routine eye exams are identified by a diagnosis code in the following table. CPT 92015 (Determination of refractive state) submitted on the same date of service as a routine eye exam (92002, 92004, 92012 and 92014) will not receive separate reimbursement.

Providers can submit claims for routine eye exams online through EyeMed's provider website: eyemedvisioncare.com. Call the EyeMed Provider Relations line at 1-888-581-3648 for assistance.

ICD-10 Diagnosis Code	Description
H52.00	Hypermetropia, unspecified eye
H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.10	Myopia, unspecified eye
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.209	Unspecified astigmatism, unspecified eye
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.219	Irregular astigmatism, unspecified eye
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.229	Regular astigmatism, unspecified eye
H52.31	Anisometropia
H52.32	Aniseikonia
H52.4	Presbyopia
H52.511	Internal ophthalmoplegia (complete) (total), right eye
H52.512	Internal ophthalmoplegia (complete) (total), left eye
H52.513	Internal ophthalmoplegia (complete) (total), bilateral
H52.519	Internal ophthalmoplegia (complete) (total), unspecified eye
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.529	Paresis of accommodation, unspecified eye
H52.531	Spasm of accommodation, right eye
H52.532	Spasm of accommodation, left eye
H52.533	Spasm of accommodation, bilateral
H52.539	Spasm of accommodation, unspecified eye
H52.6	Other disorders of refraction

ICD-10 Diagnosis Code	Description
H52.7	Unspecified disorder of refraction
H53.001	Unspecified amblyopia, right eye
H53.002	Unspecified amblyopia, left eye
H53.003	Unspecified amblyopia, bilateral
H53.009	Unspecified amblyopia, unspecified eye
H53.011	Deprivation amblyopia, right eye
H53.012	Deprivation amblyopia, left eye
H53.013	Deprivation amblyopia, bilateral
H53.019	Deprivation amblyopia, unspecified eye
H53.039	Strabismic amblyopia, unspecified eye
H53.041	Amblyopia suspect, right eye
H53.042	Amblyopia suspect, left eye
H53.043	Amblyopia suspect, bilateral
H53.049	Amblyopia suspect, unspecified eye
H53.10	Unspecified subjective visual disturbances
H53.71	Glare sensitivity
H53.72	Impaired contrast sensitivity
H53.8	Other visual disturbances
H53.9	Unspecified visual disturbance
Z01.00	Encounter for examination of eyes and vision without abnormal findings
Z01.01	Encounter for examination of eyes and vision with abnormal findings

Medical vs Routine Eye Exam Billing

The chief complaint or reason for visit should be the primary diagnosis on the claim, and this determines whether you bill a medical or routine eye exam.

To bill Fallon Health, the chief complaint or reason for visit must be medical in nature and reflected as the primary diagnosis code on the claim line.

When the patient has scheduled a routine eye exam (no medical complaints or symptoms) and as part of the exam a medical problem is identified, the eye exam is billed to EyeMed with a routine diagnosis code reflected as the primary diagnosis code on the claim line. The diagnosis code for the medical condition identified during the exam is reported as a secondary diagnosis on the claim line. In this scenario, it is incorrect to bill a routine eye exam to EyeMed and a medical eye exam to Fallon Health.

Billing for Presbyopia-Correcting (P-C) and Astigmatism-Correcting (A-C) Intraocular Lenses (IOLs)

Facility charges

The Plan does not make separate reimbursement for an IOL inserted subsequent to cataract extraction. Payment for the IOL is packaged into the payment for the cataract extraction procedure (CPT codes 66982, 66983, 66984). Reimbursement for cataract extraction includes the cost of a conventional monofocal IOL. The HCPCS code for the P-C or A-C IOL may also be reported on the claim for the cataract extraction/lens replacement procedure even though the Plan does not cover that part of the service.

Physician charges

For an IOL inserted following removal of a cataract in a physician's office, the Plan makes separate payment for the IOL. The physician should bill for the cataract extraction/lens replacement procedure

and a conventional monofocal IOL (V2632), regardless of whether a conventional monofocal IOL is inserted. The HCPCS code for the P-C or A-C IOL may also be reported on the claim for the surgical cataract extraction/lens replacement procedure even though the Plan does not cover that part of the service.

Code	Description
V2787	Astigmatism correcting function of intraocular lens
V2788	Presbyopia correcting function of intraocular lens

For additional information on billing for P-C and A-C IOLs, see Medicare Claims Processing Manual Chapter 32, Section 120 - Presbyopia-Correcting (P-C IOLS) and Astigmatism-Correcting Intraocular Lenses (A-C IOLs) (General Policy Information).

The list of Medicare-covered PC- and A-C IOLS can be accessed on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index?redirect=/HospitalOutpatientPPS/01_overview.asp.

Ophthalmologic Avastin (bevacizumab)

Claims (professional and facility) for bevacizumab for ophthalmologic indications should be submitted using HCPCS code J9035 (injection, bevacizumab, 10 mg), bill one unit per eye.

There is one exception: outpatient hospitals and ambulatory surgical centers reimbursed under Medicare OPPS or ASC payment methodology use HCPCS code C9257 (injection, bevacizumab, 0.25 mg) to report ophthalmologic bevacizumab.

The Plan will not require Invoices for ophthalmologic bevacizumab effective for dates of service on or after October 1, 2021.

Tonometry for MassHealth ACO members

Effective March 1, 2022, tonometry (CPT 92100) is not separately reimbursed when performed as part of a comprehensive eye examination, a consultation or a screening service.

Serial tonometry (separate procedure) with multilple measurements of intraocular pressure (CPT 92100), is separately reimbursed, when performed to monitor a plan member who has glaucoma (H40.10X0-H40.9, H42, Q15.0).

Policy history

Origination date:	11/09/2005
Previous revision date(s):	05/10/2006, 05/09/2007 07/01/2012 - renamed to Vision Services Payment Policy. Updated content to reflect FCHP's relationship with EyeMed Vision Care effective July 1, 2012. 03/01/2013 - Updated list of routine diagnoses. 11/01/2015 - Moved to new Plan template and updated reimbursement and billing/coding guidelines sections with ICD-10 codes. 01/01/2017 - Annual review.
Connection date & details:	May 2017 – Updated refraction reimbursement language. July 2018 – Annual review, no updates. July 2019 – Updated the reimbursement section. October 2020 – Updated reimbursement section for NaviCare and Fallon Medicare Plus. April 2021 – Updated diagnosis codes for routine eye exams; clarified medical vs. routne eye exam billing; added information about billing for presbyopia-correcting and astigmatism-correcting intraocular lenses. October 2021 – Updated to include billing information for ophthalmologic Avastin (bevacizumab).

January 2022 – Updated to include information on billing for tonometry (CPT 92100).

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.