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## Vision Services

### Policy

Harvard Pilgrim reimburses contracted ophthalmologists and optometrists for the provision of ophthalmology services in accordance with specific state practice regulations. Vision benefits may vary greatly among employer groups. For benefit determination, call the Provider Service Center at 800-708-4414.

### Policy Definition

*Vision Services* involve the diagnosis and medical and surgical treatment of eye diseases, disorders and injuries. Services include routine eye exams, special ophthalmological services, and surgeries related to the eye and ocular adnexa.

### Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. (Refer to [Referral, Notification and Authorization](#) for more information.)

### HMO/POS/PPO

- Referral required for specialist services for HMO and in-network POS members
  - Referral not required for routine annual eye examination
  - Referral not required for *diabetic* eye exams when billed with a diabetic diagnosis in the primary position
  - Referral not required for one urgent evaluation and follow-up visit for Maine members
- Authorization required for blepharoplasty surgery and vision hardware (Refer to the [Authorization Policy](#) for specific requirements.)

### Open Access HMO and POS

For [Open Access HMO and Open Access POS](#) products, no referral is required to see a contracted specialist.

### Harvard Pilgrim Reimburses<sup>1</sup>

#### HMO/POS/PPO

#### Routine Eye Care

- Routine eye examinations are reimbursed according to the members benefit limit as applicable.
- Intermediate and comprehensive ophthalmic services as defined by CPT.

#### Non-routine or Special Ophthalmologic Services

- Gonioscopy rendered as part of medical evaluation and management visit.
- Orthoptics
- Use of ophthalmic endoscopy, when billed in addition to appropriate primary procedures (Refer to “Provider Billing Guidelines and Documentation” for additional reimbursement information.)
- Pachymetry, for specific diagnosis codes limited to one test per member, per lifetime (Refer to “Provider Billing Guidelines and Documentation” for additional reimbursement information.)
- Ophthalmic echography
- Retisert (fluocinolone acetonide) intravitreal implant for the treatment of chronic non-infectious posterior segment uveitis (greater than one-year duration), and in situations where there is documentation of member intolerance, or lack of significant response to conventional treatment including peri-ocular injections, and/or short course (less than three months) of systemic corticosteroid therapy.

#### Eye Surgery

Harvard Pilgrim follows CMS guidelines for global payment periods. The global surgical period [0, 10, 90 days] is determined using the CMS designation and guidelines for each surgical CPT code.

The following services are reimbursed at a rate inclusive of all sessions within the CMS-designated global surgical period. This list is not all-inclusive:

- Choroidal neo-vascularization
- Destruction of localized retinal lesion
- Destruction of progressive retinopathy
- Prophylaxis of retinal detachment
- Retinal repair
- Trabeculoplasty

Harvard Pilgrim reimburses surgical services including, but not limited to:

- Blepharoplasty surgery
- Intraocular lens exchange
- Keratoplasty/corneal surgery
- Processing and transportation of corneal tissue
- Strabismus surgery
- Vitrectomy

Refer to *Surgery, Outpatient Surgery, and Outpatient Facility Fee Schedule policies* for information on general surgical reimbursement methodologies, such as separately reimbursed services, bundled services, bilateral surgeries, mul-tiple surgical procedures, add-on codes, unlisted codes, assistant surgeons, team surgery, co-surgery, anesthesia ser-vices and surgical trays.

### Vision Hardware

Harvard Pilgrim reimburses vision hardware for special medical conditions only and is subject to the member's benefit and benefit coverage limits. Prior notification is required.

Condition	Vision Hardware
Post-cataract surgery/pseudophakes (with intraocular lens implant excluding Crystalens)	Standard eyeglass lenses and eyeglass frames within 90 days of the cataract surgery or replacement lenses within 90 days of the first eye examination following cataract surgery due to a change in prescription of .50
Post-cataract aphakes surgery (without lens implant)	Either contact lenses or eyeglasses (benefit limit on frames; no limit on lenses), but not both
Keratoconus	Contact lenses (including replacement contact lenses)
Post-retinal detachment surgery	Either contact lenses or eyeglasses, but not both
Pseudoaphakes or aphakes only	UV coating or tinting, when prescribed

### Harvard Pilgrim Does Not Reimburse

#### HMO/POS/PPO

- Crystalens implant, including as a replacement lens for post-cataract surgery
- Destruction of localized lesion of choroid, transpupillary thermotherapy
- Destruction of macular drusen
- Experimental use of botulinum toxins type A and botulinum toxin type B
- Hospital-mandated physician on-call services
- Lasik surgery
- Punctum plugs separately
- Radial keratotomy

- Refractive surgery including excimer laser and orthokeratology for correction of myopia, hyperopia and astigmatism
- Retisert for conditions other than those specified
- Preferential looking test when billed with an E&M service
- Refraction services will not be reimbursed separately when performed on the same day as an eye exam or an E&M service. Only the eye exam or the E&M service will be reimbursed.

### Member Cost-Sharing

Services subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible).

### Provider Billing Guidelines and Documentation

#### Coding<sup>2</sup>

Code	Description	Comments
65771	Radial keratotomy	Not reimbursed
65782	Ocular surface reconstruction	
66990	Use of ophthalmic endoscope (add-on code intended to be reported with a specified list of other intraocular surgical procedures)	May only be billed and reimbursed with codes: 65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041-67043, 67107, 67108, 67110 and 67113
76514	Corneal pachymetry	Reimbursement is limited to one test per member, per lifetime, for only the following diagnosis codes: <b><u>ICD-10 Covered Indications</u></b>
92015	Determination of refraction	Refraction services will not be reimbursed separately when performed on the same day as an eye exam or an E&M service.
92071	Fitting of contact lens for treatment of ocular surface disease	Reimbursement is limited to only the following diagnosis codes when submitted as the primary diagnosis: <b><u>ICD-10 Covered Indications</u></b>
92072	Fitting of contact lens for management of keratoconus, initial fitting	Reimbursement is limited to only the following diagnosis codes when submitted as the primary diagnosis: <b><u>ICD-10 Covered Indications</u></b>
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	Reimbursement is limited to only the following diagnosis codes: <b><u>ICD-10 Covered Indications</u></b>
92499	Unlisted ophthalmological service or procedure	Not reimbursed in addition to an E&M service when billed for preferential looking test.
99026, 99027	Hospital mandated physician on call services	Not reimbursed
99173	Screening test of visual acuity	Not reimbursed when billed with an E&M service
A4262 A4263	Temporary or permanent lacrimal duct implants	Provider liable — payment included in the allowance of another service

## PAYMENT POLICIES

Code	Description	Comments
J3490	Unclassified drugs	NDC is required.
J7311	Fluocinolone Acetonide, intravitreal implant	Retisert. Clinical documentation that supports the covered condition is required. First time claim submissions can be submitted on paper with operative notes for consideration. If notes are not submitted, the claim will deny requesting notes.
V2500	Contact lens, PMMA, spherical, per lens	Reimbursement is limited to only the following diagnosis codes:  <b><u>ICD-10 Covered Indications</u></b>
V2501	Contact lens, PMMA, toric or prism ballast, per lens	
V2502	Contact lens PMMA, bifocal, per lens	
V2503	Contact lens, PMMA, color vision deficiency, per lens	
V2510	Contact lens, gas permeable, spherical, per lens	
V2511	Contact lens, gas permeable, toric, prism ballast, per lens	
V2512	Contact lens, gas permeable, bifocal, per lens	
V2520	Contact lens, hydrophilic, spherical, per lens	
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	
V2522	Contact lens, hydrophilic, bifocal, per lens	
V2523	Contact lens, hydrophilic, extended wear, per lens	
V2530	Contact lens, scleral, gas impermeable, per lens	
V2531	Contact lens, scleral, gas permeable, per lens	
V2787	Astigmatism-correcting function of intraocular lens	
V2788	Presbyopia correcting function of intraocular lens	Not reimbursed

**Other Information**
**Routine Eye Examinations**

- *Bill routine eye examinations using the appropriate diagnosis code:*

**ICD-10 Covered Indications**
**Bilateral Services**

Harvard Pilgrim uses the Center for Medicare and Medicaid Services (CMS) Relative Value File Status indicators in the National Physician Fee Schedule (NPFs) to determine which codes are eligible for bilateral reimbursement.

It is inappropriate to append modifier 50, LT or RT with procedure codes with a Bilateral Indicator of 2. The codes below will not be reimbursed when modifier 50, LT or RT is appended, as the code descriptions are bilateral in nature.

76514	92012	92020	92081	92227	92270	92286	92314	92342	92370
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## PAYMENT POLICIES

76516	92014	92025	92082	92228	92275	92287	92315	92352	92371
76519	92015	92060	92083	92250	92283	92310	92316	92354	92499
92002	92018	92065	92100	92265	92284	92311	92340	92355	
92004	92019	92072	92136	92260	92285	92312	92341	92358	

The appropriate billing method for these services is to bill the procedure code on a single line without a modifier such as 50, LT or RT, and with one unit of service.

To report a unilateral service, append the modifier 52 (reduced service) and the LT or RT modifier.

### Vision Hardware

- Bill eyeglasses for pseudophakes with IOL, aphakes or post-retinal detachment using the appropriate supply codes or the following HCPCS codes:
  - Frames: V2020 or V2025
  - Lenses: V2100–V2499 (representing lenses provided)
  - UV coating: V2755 (pseudophakes and aphakes only)
  - Tinting: V2744–V2745
- Bill contact lenses for aphakes without lens implant or post-retinal detachment surgery using HCPCS codes V2500–V2599 with RT or LT modifier or:
  - Replacement lenses for aphakes, post-retinal detachment or keratoconus bill: CPT 92326 with RT or LT modifier

### Unlisted Drugs

Electronic claim submitters:

- 837P — Report the unlisted J code in the SV101-2, loop 2400 and the NDC Number with N4 qualifier in the LIN segment, loop 2410. When reporting NDC the CTP segment is required — both CTP04 (NDC count) and CTP05 (unit of measure)
- 837I — Report the unlisted J code in the SV202-2, loop 2400 and the NDC Number with N4 qualifier in the LIN segment, loop 2410. When reporting NDC in LIN segment the CTP segment is required — both CTP04 (NDC count) and CTP05 (unit of measure)

Paper claim submitters:

- CMS-1500 form: Report the unlisted J code in 24D and units in 24G. To report NDC: In shade area of the line-item field (24A-24G), enter the N4 qualifier immediately followed by 11-digit NDC number — left justified, enter 1 space then qualifier for dispensing unit of measure followed by quantity.
- UB-04 form: Report the unlisted J code in Form Locator 44 and units in Form Locator 46. To report NDC: In Form Locator 43 enter the N4 qualifier immediately followed by 11-digit NDC number without hyphens — left justified. NDC will be followed immediately by the qualifier for dispensing unit of measure followed by quantity

### General Billing

- *Bill using either E&M visit codes or ophthalmology visit codes*
- *Bill the following services only once per eye for all sessions within their designated CMS global surgical period:*

65855	66761	67101	67105	67141	67145
67208	67210	67218	67220	67227	67228

### Related Policies

#### Payment Policies

- Bilateral Services and CPT Modifier 50

PAYMENT POLICIES
 

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- Cosmetic, Reconstructive and Restorative Procedures
- Evaluation and Management
- Non-Covered Services
- Outpatient Surgery
- Outpatient Facility Fee Schedule
- Surgery

Clinical/Authorization Policies

- Cosmetic, Reconstructive and Restorative Procedures
- New Technology Assessment and Non-Covered Services
- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

Billing & Reimbursement

- Claims Submission Guidelines

Referral, Notification & Authorization

- Prior Authorization Policy
- Notification Policy

Medical Drug Program (CVS Health-Novologix)

## PUBLICATION HISTORY

10/01/01	original documentation
04/01/02	added Maine mandate; ophthalmic bimetry code; clarified photo-therapy coding
01/01/03	annual update; First Seniority information added
04/01/03	2003 coding update
04/30/04	coding update
01/01/05	update to pachymetry diags; routine eye diag-amblyopia, strabismus removed; non-coverage for Crystalens implant and Sclera lens, liquid bandage device
01/01/06	annual review and coding update; reimburse refraction, clarified modifier 50 billing, corrected covered pachymetry diagnoses; First Seniority presbyopic IOL coverage added; listed Botox covered diags
01/31/07	annual update; added Retisert coverage conditions and additional covered diags for Myobloc
10/31/07	annual review; added additional covered diags for Botox; clarified global period for eye surgeries
01/31/08	annual coding update
10/31/08	annual review; added replacement lens coverage related to post-cataract surgery and Keratoconus, added covered diags for contact lens fitting
01/31/09	annual coding update; 67038 deleted from coding table; updated diagnoses for botox
08/15/09	annual review; edits for clarity; added references to related policies
09/15/10	annual review; minor edits for clarity
01/15/11	annual coding update
09/15/11	annual review; clarification of routine eye exams; update to related policies
11/15/11	minor edits for clarity; added Notification Policy to related policies
01/01/12	removed First Seniority Freedom information from header
01/15/12	annual coding update
08/15/12	annual review; added new covered diagnosis for contact lenses
01/15/13	added no separate reimbursement of refraction services billed on same day as E&M or eye exams
10/15/13	annual review; administrative edits
06/15/14	added <i>Connecticut Open Access HMO</i> referral information to prerequisites
10/15/14	annual review; updated policy statement to indicate that benefits may vary; administrative edits
11/15/14	removed diagnosis 371.60-371.62 from CPT 92071 for dates of service after 11/15/14
01/15/15	annual coding update
07/15/15	ICD-10 coding update
08/15/15	added bilateral procedure codes not eligible for modifier 50, LT or RT for dates of service 11/01/15; added audit payment policy to related policies
10/15/15	annual review; additional diagnosis coding for contact lenses, removed record the authorization number in box 23 for blepharoplasty & other services under general billing guidelines, updated billing guidelines
01/15/16	annual coding update
02/15/16	added Medical Policy link to J0585-J0588, administrative edits

PAYMENT POLICIES
 

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05/15/16	removed lifetime limitation language from CPT 92071 and 92072
07/15/16	CPT 92132 added no longer reimbursed as of 07/10/16 date of service, added Optical Coherence Tomography Medical Policy as a related policy
10/15/16	added HCPC codes for Lacrimal duct implants
10/15/17	annual review; no changes
02/01/18	updated Open Access Product referral information under Prerequisites
07/02/18	updated CPT 92132; use CPT 92326 for keratoconus contact lenses
11/01/18	annual review; removed ICD-9 references, removed deleted CPT code 92140 under bilateral services; updated related policies; updated vision hardware for contact and replacement lenses; administrative edits
02/01/19	annual coding update
11/01/19	annual review; added/removed related medical policies; administrative edits; removed reference to Botulinum Toxin and Ophthalmic Scanning
02/03/20	annual coding update
11/02/20	annual review; updated Provider Billing Guidelines and Documentation
11/01/21	annual review; no changes

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<sup>1</sup>This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

<sup>2</sup>The table may not include all provider claim codes related to vision services.