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# Eye Appliances

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This section contains general information about program coverage of eye appliances as specified in *California Code of Regulations* [CCR], Title 22, Section 51317. Refer to specific policy sections for additional information.

## General Information

### Program Coverage

Eye appliances are only covered by the written prescription of a physician or optometrist, subject to the provisions outlined in the policy sections of this manual.

### Covered Eye Appliances

For recipients that fall into one of the exempt categories, the following eye appliances are covered by Medi-Cal:

- Eyeglass frames that conform to the American National Standards Institute (ANSI) Requirements for Dress Ophthalmic Frames (Z80.5) and meet the requirements listed under “Program Coverage” in the *Eyeglass Frames* section of this manual
- Prescription eyeglass lenses that conform to ANSI Requirements for First Quality Prescription Lenses (Z80.1) and meet the requirements listed under “Program Coverage” in the *Eyeglass Lenses* section of this manual
- Contact lenses that conform to the federal Food and Drug Administration (FDA) approved applications for hydrophilic lenses; ANSI Requirements for First Quality Contact Lenses (Z80.2) for hard and gas permeable lenses; and meet the requirements listed under “Program Coverage” in the *Contact Lenses* section of this manual
- Low vision optical aids, excluding electronic magnification devices, that meet the requirements listed under “Program Coverage” in the *Low Vision Aids* section of this manual
- Prosthetic eyes with a written prescription by a physician or optometrist that meet the requirements listed under “Program Coverage” in the *Prosthetic Eyes* section in this manual.



### Eye Appliance Items With No Price on File

All eye appliance items with no price on file are manually priced based on invoice or catalog page. Providers have a choice of whether the pricing is done at the time of TAR adjudication or at the time of claim processing.

In order to have pricing done at the time of TAR adjudication, the provider must include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at the Department of Health Care Services (DHCS) Vision Services Branch (VSB) will determine the price and assign a Pricing Indicator (PI) of 3. When this is done, the claim can be submitted without the invoice or catalog page. Providers must enter the 10-digit TCN followed by the PI of 3 (eleventh digit) in the *Prior Authorization Number* field (Box 23) of the *CMS-1500* claim form.

In order to have pricing done at the time of claim processing, the provider does not have to include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at DHCS VSB will assign a PI of 0. When this is done, the claim must be submitted with the invoice or catalog page. Providers must enter the 10-digit TCN followed by the PI of 0 (eleventh digit) in the *Prior Authorization Number* field (Box 23) of the *CMS-1500 claim* form.

**Note:** Authorization of “By Report” procedure codes is only a determination that the appliance and associated services are medically necessary. Determination of reimbursement fees in each case will be made by Medi-Cal. If a TAR is approved, a claim associated with that TAR that fails to meet other Medi-Cal billing requirements may be denied.

### **Supplemental Eye Appliances**

In addition to the one pair of eyeglasses (single vision or bifocal) or medically necessary contact lens covered by Medi-Cal, coverage of supplemental eye appliances is limited to the following:

- Two pairs of single vision eyeglasses, one for distance vision and one for near vision, in lieu of bifocal eyeglasses, when bifocal lenses cannot be worn satisfactorily because of non-adaptation or safety reasons
- Single vision or bifocal eyeglasses for concurrent use with medically necessary contact lenses
- Low vision aids prescribed for visually impaired recipients
- Prosthetic eyes and prosthetic scleral shells
- Bandage contact lenses

## Non-Covered Eye Appliances

The following eye appliances are not Medi-Cal benefits:

- Eyeglasses used solely for protective, cosmetic, occupational or avocational purposes
- Spare pairs of eyeglasses
- Single vision eyeglasses in addition to multifocals
- Eyeglasses prescribed for other than the correction of refractive errors or binocularity anomalies
- Double segment bifocal or no-line multifocal lenses
- Multifocal contact lenses
- Eyeglasses to be used alternately with contact lenses

## Replacement of Lost, Stolen, Broken or Damaged Appliances

Lost, stolen, broken or significantly damaged eye appliances may not be replaced unless a recipient or recipient's representative supplies the provider with a signed statement. The statement must certify that a loss, breakage or damage was beyond the recipient's control and must include the circumstances of the loss or destruction and the steps taken to recover the lost item. A recipient's signed statement about the circumstances of replacement must be retained in the recipient's file for at least three years.

Providers will not be held responsible for inaccurate statements by recipients. Providers may certify that specific items require replacement due to normal wear and tear or aging and that no abuse is evident. There are no time restrictions for replacement or repair of eye appliances.

## Record Keeping

Providers must make a reasonable effort to ascertain and record the age, source and characteristics of a recipient's most recent ophthalmic correction. Reviewing provider records and asking recipients about prior ophthalmic corrections will satisfy this requirement.

### Date Appliance Delivered

*Welfare and Institutions Code Section 14043.341* requires providers to obtain and keep a record of Medi-Cal recipients' signatures when dispensing a product or prescription or when obtaining a laboratory specimen

Therefore, dispensing optical providers (ophthalmologists, optometrists, and dispensing opticians) who dispense a device (eye appliances) requiring a written order or prescription must maintain the following items in their files to qualify for Medi-Cal reimbursement:

- Signature of the person receiving the eye appliance
- Medi-Cal recipient's printed name and signature
- Date signed
- Prescription number or item description of the eye appliance dispensed
- Relationship of the recipient to the person receiving the prescription if the recipient is not picking up the eye appliance

#### Undeliverable Custom-Made Appliances

When custom-made eye appliances cannot be delivered to recipients, providers must include documentation in the medical record that shows diligent attempts to make the delivery or the impossibility of delivery. Acceptable documentation would include, but not be limited to, certificate of mailing, telephone logs, etc.

Claims for custom-made eye appliances are reimbursed at 100 percent of the authorized maximum allowable. Providers must retain undeliverable custom-made eye appliances for one year from the date of service if reimbursement is received according to the conditions described above. These appliances must be ready for delivery on demand to the recipient or to a representative of the Department of Health Care Services (DHCS).

#### Prescription Requirements for Dispensing Providers

Providers who dispense the prescription of another provider must keep on record a current prescription with the prescriber's signature.

## **Billing Information**

### **Dispensing Fees**

Providers are restricted to billing the following CPT® codes for dispensing of ophthalmic lenses:«

««««**Table of CPT Codes for Dispensing of Ophthalmic Lenses**»»»»

<b>CPT Code</b>	<b>Description</b>
92340	Fitting of spectacles, except for aphakia; monofocal
92341	Fitting of spectacles, except for aphakia; bifocal
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal
92352	Fitting of spectacle prosthesis for aphakia; monofocal
92353	Fitting of spectacle prosthesis for aphakia; multifocal

Refer to the *Rates: Maximum Reimbursement for Dispensing and Repair Fees* section, “Program Coverage” in the *Eyeglass Lenses* section, and the *Eyeglass Lenses: Examples* section of this manual for more information.

Eyeglass cases and frame adjustments, alignment and straightening are included in the Medi-Cal reimbursement for dispensing fees of ophthalmic lenses.



### ICD-10-CM Diagnosis Codes

ICD-10-CM diagnosis codes must be present and valid on all claims for the following eye appliance procedures for payment. For a list of procedures and their corresponding ICD-10-CM diagnosis codes, refer to the *Professional Services: Diagnosis Codes* section in this manual.

- Bandage contact lenses (HCPCS code V2599)
- Slab off prism (HCPCS code V2710)
- Tint, photochromic (HCPCS code V2744)
- Tint, solid, gradient, or equal (HCPCS code V2745)
- Ultra violet (UV) (HCPCS code V2755)

For the conditions specified below, primary and/or secondary ICD-10-CM diagnosis codes must be present and valid on all claims for frames, ophthalmic lenses, and/or lens dispensing fees to justify payment.

- When two pairs of single vision eyeglasses are prescribed in lieu of bifocals for recipients 38 years of age or older.
- When multifocal or nearpoint eyeglasses (in addition to the distance prescription) are prescribed for recipients younger than 38 years of age.

### Additional Documentation

When frequency limits are exceeded, providers may be required to also submit the following documentation with claims for the repair or replacement of eye appliances:

- Patient's name and date
- Circumstances for repair or replacement
- A statement certifying that a loss, breakage or damage was beyond the patient's control and the steps taken to recover the lost item
- Patient's signature or the signature of patient's representative or guardian

## Balance Lenses

Balance lenses ordered from PIA optical laboratories should be billed with the same procedure code for dispensing (CPT codes 92341 thru 92343 or 92352 thru 92353) as for the lens that was prescribed for the sighted eye. For example, if a patient requires a balance lens with a bifocal prescription, CPT codes 92341 should be billed with a quantity of “2.” Refer to the requirements listed under “Program Coverage” in the *Eyeglass Lenses* section of this manual.

## Headbands

Claims for headbands require authorization and should be billed with HCPCS code V2799 (vision item or service, miscellaneous). Providers should include the following documentation in the *Medical Justification* field of the 50-3 TAR form:

- History of medical and/or physical conditions (for example, cerebral palsy, multiple sclerosis, seizures, epilepsy, autism, Down Syndrome, Attention Deficit Disorder, brain trauma, physical handicap, etc.) that hinder the continuous wearing of eyeglasses.
- History of participation in physical or athletic activities.
- History of wearing headbands in the past.

Refer to the *TAR Completion for Vision Care* section in this manual for instructions about completing the 50-3 TAR form.

## Unlisted Eye Appliances

Unlisted eye appliances must be billed with HCPCS code V2799 (vision item or service, miscellaneous). Authorization for HCPCS code V2799 is required from DHCS VSB prior to dispensing the appliance. Providers must include a complete description of the appliance and justification for medical necessity in the *Medical Justification* field of the 50-3 TAR form. Because unlisted eye appliances are “By Report,” laboratory invoices or catalog pages detailing the wholesale cost of the eye appliances must be attached to the claim for manual pricing.

## Aphakia/Pseudophakia: Medicare/Medi-Cal Crossovers

The Omnibus Budget Reconciliation Act of 1990 mandates limited coverage of eyewear for recipients with a diagnosis of aphakia (ICD-10-CM diagnosis codes H27.00 thru H27.03 or Q12.3) and pseudophakia (ICD-10-CM code Z96.1).

### Billing Medicare

All claims for eye appliances for recipients with aphakia must be billed to Medicare prior to billing Medi-Cal. For pseudophakic recipients, Medicare reimbursement is limited to one pair of conventional eyeglasses after cataract surgery with insertion of an intraocular lens implant. Claims for initial post-surgery eyeglasses for pseudophakic recipients must be billed to Medicare.

Medicare claims for eye appliances should be billed to Noridian Administrative Services, the Durable Medical Equipment Medicare Administrative Contractor. Refer to the *DME MAC Jurisdiction D Online Supplier Manual* for Medicare policy regarding lenses and frames.

### Billing Medi-Cal

After Medicare benefits are exhausted, Medi-Cal will cover the replacement of ophthalmic lenses and frames or contact lenses, including changes in prescription, as well as lost, broken, stolen or scratched lenses for Medicare/Medi-Cal recipients.

When billing Medi-Cal for Medicare exhausted benefits, providers must enter a "1" (benefits exhausted) in the *Resubmission Code* field (Box 22) on the *CMS-1500* and attach a copy of the *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* to the claim.

**Note:** Because the initial pair of post-surgery eyeglasses for pseudophakic recipients is billed to Medicare, providers must send the optical order to a non-PIA optical laboratory for lens fabrication. When billing for ophthalmic lenses, providers are instructed to use HCPCS codes V2100 thru V2499 and when billing for miscellaneous lens items with HCPCS codes V2700 thru V2755, V2760 thru V2762 and V2781 thru V2784. Lens dispensing fees (CPT codes 92340 thru 92342, and 92352 thru 92353) should not be billed in this case.

HCPCS codes V2118, V2218, V2219, V2315, V2318, and V2319 are non-covered benefits.

**«Legend»**

«Symbols used in the document above are explained in the following table.»

<b>Symbol</b>	<b>Description</b>
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.