



**Date:** 11/8/06

**Medi-Cal**

**Provider Notice: #0065**

**Subject: Vision Care HIPAA Updates – Effective 7/1/06**

Effective for dates of service on or after 7/1/06, the following changes will be for vision services, pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

- Convert Medi-Cal interim codes to nation HCPCS Level II and CPT-4 Level I codes.
- Eliminate all Medi-Cal qualifying codes and replace them with national CPT-4 and HCPCS modifiers. Additionally, modifier X1 – X9 are no longer used for vision services.
- Replace the *Payment Request for Vision Care and Appliances* (45-1) claim form with the *CMS 1500* claim form.

A detailed summary of the policy changes is listed below.

<b>Medi-Cal Interim Code</b>	<b>Description</b>	<b>HCPCS/ CPT-4 Code</b>	<b>Description</b>
Z2700	Low vision evaluation, fitting and subsequent supervision, including six months follow-up care	92499	Unlisted ophthalmological service or procedure
Z2704	Detailed biomicroscopy slit lamp evaluation	None	Not a Medi-Cal benefit for services performed after 6/30/06

Z2706	Contact lens examination	92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
Z2706	Contact lens examination	92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye
Z2706	Contact lens examination	92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes
Z2708	Out-of-office call	99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
Z2710	Mileage-per mile one way beyond a ten-mile radius from point of origin	None	Not a Medi-Cal benefit for services performed after 6/30/06
Z2712	Diagnostic closure of the lacrimal punctum; by absorbable plug, one or more closures, incl. office visit	68761	Closure of the lacrimal punctum; by plug, each
Z2900	Contact lens, PMMA or gas permeable replacement	V2500	Contact lens, PMMA, spherical, per lens
Z2900	Contact lens, PMMA or gas permeable replacement	V2501	Contact lens, PMMA, toric or prism ballast, per lens
Z2900	Contact lens, PMMA or gas permeable replacement	V2510	Contact lens, gas permeable, spherical, per lens
Z2900	Contact lens, PMMA or gas permeable replacement	V2511	Contact lens, gas permeable, toric, prism ballast, per lens
Z2902	Contact lens, hydrophilic, replacement	V2520	Contact lens, hydrophilic, spherical, per lens
Z2902	Contact lens, hydrophilic, replacement	V2521	Contact lens, hydrophilic, toric or prism ballast, per lens

Z2904	Thermal hydrophilic lens care kit	None	Not a Medi-Cal benefit for services performed after 6/30/06
Z2906	Bandage contact lenses	V2599	Contact lens, other type (bandage contact lens)
Z2908	Contact lenses, extended wear, replacement	V2513	Contact lens, gas permeable, extended wear, per lens
Z2908	Contact lenses, extended wear, replacement	V2523	Contact lens, hydrophilic extended wear, per lens
Z2910	Arm with adjustable pad	V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2912	Front zyl (replace or repair)	V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2914	Front combination or metal (replace or repair)	V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2916	Temples - all types (replace)	V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2918	Occluder, clip patch style	V2770	Occluder lens, per lens
Z2920	Occluder, cup	V2770	Occluder lens, per lens
Z2926	Headband	V2799	Vision service, miscellaneous
Z2928	Nosepads, nosepad covers, temple covers (limited to one pair in each category)	V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2930	Dispensing fees - Single vision lens	92340	Fitting of spectacles, except for aphakia; monofocal
Z2930	Dispensing fees - Single vision lens	92352	Fitting of spectacles prosthesis for aphakia; monofocal
Z2932	Dispensing fees, Bifocal lens	92341	Fitting of spectacles, except for aphakia; bifocals
Z2932	Dispensing fees - Bifocal lens	92353	Fitting of spectacles prosthesis for aphakia; multifocal
Z2934	Dispensing fees - Trifocal lens	92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal

Z2936	Dispensing fees - Frames	None	Not a Medi-Cal benefit for services performed after 6/30/06
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## Policy Requirements/Changes

- Vision service CPT-4 codes 99201 – 99215, 99241 – 99245 and HCPCS codes V2623 – V2629 maintain current policy and pricing.
- HCPCS code V2797 (vision supply, accessory and/or service component of another HCPCS vision code) cannot be billed with HCPCS code V2020 (frames, purchases) on the same date of service.
- CPT-4 code 99056 (out-of-office call) must be billed with one of the following CPT-4 codes (92002, 92004, 92012, 92014, 92310 – 92312, 92205 – 99215 and 92499) on the same date of service.
- CPT-4 codes 92225 (extended ophthalmoscopy) and 92250 (fundus photography) cannot be billed on the same date of service.
- CPT-4 code 92135 is reimbursable for optometrists.
- Low vision evaluation must be billed with CPT-4 code 92499 (unlisted ophthalmological service or procedure).
- Bandage contact lenses must be billed with HCPCS code V2599 (contact lens, other type).
- Frame repairs and parts replacements must be billed with HCPCS code V2797 (vision supply, accessory and or service component of another HCPCS vision code). The new maximum allowable for HCPCS code V2797 includes both the repair service and frame part(s). Frame parts include nosepad are with adjustable pad, nosepads, nosepad covers, temples and temple covers and frame front.
- Headbands must be billed with HCPCS code V2799 (vision service, miscellaneous).
- HCPCS codes V2020, V2100 – V2121, V2200 – V2221, V2300 – V2321, V2410 – V2430, V2500 – V2523, V2599, V2600, V2610, V2615, V2770, V2797 and V2799 must be billed with the following lens replacement codes:
  - L1 (general standard of 20 degree or .5 diopter sphere or cylinder change met)
  - L2 (replacement due to loss or theft)
  - L3 (replacement due to breakage or damage)
  - L5 (replacement due to medical reason)

## Modifiers

### Modifier Replace Qualifying Codes

Effective for dates of service on or after 7/1/06, Medi-Cal qualifying codes currently used will be replaced with national modifiers.

The following modifiers are required with the CPT-4 and HCPCS codes listed below:

<b>CPT-4 Code</b>	<b>Modifier</b>
	SC, E1, E2, E3,
68761	E4
92310	22, SC
92311	22, SC
92312	22, SC
92340	NU, RP
92341	NU, RP
92342	RP, KX
92352	NU, RP
92353	NU, RP
99056	22

<b>HCPCS Code</b>	<b>Modifier</b>
V2020	NU, RP
V2100 -	
V2121	NU, RP
V2200 -	
V2221	NU, RP
V2300 -	
V2321	RP, KX
V2410 -	
V2430	NU, RP
V2500	NU, RP
V2501	NU, RP
V2510	NU, RP
V2511	NU, RP
V2513	NU, RP
V2520	NU, RP
V2521	NU, RP
V2523	NU, RP
V2599	LT, RT
V2600	NU, RP
V2610	NU, RP
V2615	NU, RP
V2770	NU, RP
V2797	RP
V2799	NU, RP

Effective for dates of service on or after 7/1/06, the following CPT-4 and HCPCS codes and national modifiers information must be present on the CMS 1500 claim form:

- All procedure codes for eye appliances and eyeglass dispensing must be billed with an appropriate modifier. Modifiers required for billing eye appliances include -NU (new equipment), -RP (repair/replacement) and -KX (specific required documentation on file).
  - Use modifier -NU when supplying or dispensing eye appliances to recipients with no prior eye appliance.

- Modifier –RP is used to indicate repair or replacement of prior eye appliances.
  - Since trifocal lenses are covered only for recipients who are current trifocal wearers, modifier –KX is billed in conjunction with
  - –RP for trifocal lenses (HCPCS codes V2300 – V2321) and the dispensing of trifocal lenses (CPT-4 code 92342) to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer.
- When billing for CPT-4 code 68761 (closure of the lacrimal punctum, by plug, each), providers must use modifier –SC (medically necessary service/supply) when temporary collagen punctual plugs are used and modifier –E1 (upper left, eyelid), -D2 (lower left, eyelid), -E3 (upper right, eyelid) and –E4 ( lower right, eyelid) when permanent silicone punctual plugs are used. Each of these listed modifiers must be billed with a quantity of 1.
  - Modifiers -22 (unusual procedural services) and -54 (surgical care only) are allowable with CPT-4 codes 65210 (removal of foreign body, external eye, conjunctival embedded), 67820 (correction of trichiasis) and 67938 (removal of foreign body, eyelid), but are not required for reimbursement.
  - Either modifier -22 or –SC may be billed with CPT-4 codes 92310 – 92312.
  - Because CPT-4 code 68761 and HCPCS code V2599 may require multiple modifiers to describe the service, providers must use separate claim lines for each procedure code/modifier combination.
  - All required modifiers, with the exception of –RP and –KX, must be billed on a single claim line.
  - Modifier X1 – X9 are no longer used for vision services.

**Diagnosis Codes (ICD-9)**

**CPT-4 Codes and HCPCS Codes and Corresponding ICD-9 Codes.**

Effective for dates of service on of after 7/1/06, ICD-9 diagnosis codes must be present and valid on all claims for the following CPT-4 and HCPCS codes. Failure to supply a valid ICD-9 code will result in denial of the claim.

**CPT-4**

<b>Code</b>	<b>Description</b>
65205	Removal of foreign body, external eye, conjunctival superficial
65210	Removal of foreign body, external eye, conjunctival embedded
65220	Removal of foreign body, corneal, without slit lamp
65222	Removal of foreign body, corneal, with slit lamp
67820	Correction of trichiasis
67938	Removal of foreign body, eyelid
68761	Closure of lacrimal punctum
68801	Dilation of lacrimal punctum

92020	Gonioscopy
92081 -	
92083	Visual field examination
92100	Serial tonometry
92135	Scanning computerized ophthalmic diagnostic imaging
92225	Extended ophthalmoscopy
92250	Fundus photography

## HCPCS

Code	Description
V2599	Bandage contact lenses
V2710	Slab off prism
V2744	Tint, photochromic
V2745	Tint, solid, gradient, or equal
V2755	Ultra Violet (UV)

To justify payment, the following primary and/or secondary ICD-9 diagnosis codes must be present on the claim when billing ophthalmic lenses and frames and lens dispensing fees for the conditions specified below:

- When two pair of single vision eyeglasses are prescribed in lieu of bifocals for recipients 38 years of age and older:
  - Primary
    - ❖ 367.4 (presbyopia)
  - Secondary
    - ❖ 368.1 (subjective visual disturbance)
    - ❖ 368.13 (visual discomfort)
    - ❖ 368.14 (visual distortions in shape and size)
    - ❖ 368.15 (other visual distortions and entopic phenomena)
    - ❖ 368.16 (psychophysical visual disturbances)
    - ❖ 368.8 (other specified visual disturbances)
    - ❖ 368.9 (unspecified visual disturbance)
- When bifocals or two pair of single vision eyeglasses are prescribed in lieu of bifocals for recipients younger than 30 years of age:
  - 367.50 (disorders of accommodation)
  - 367.51 (paresis of accommodation)
  - 367.52 (total or complete internal ophthalmoplegia)
  - 367.53 (spasm of accommodation)
  - 367.9 (unspecified disorder of refraction and accommodation)
  - 378.35 (accommodative component in esotropia)
  - 378.84 (convergence excess or spasm)

A second eye examination with refraction within 24 months is covered only when a sign or symptom indicates a need for this service. Claims billed with CPT-4 codes 92004 and 92014 must include appropriate ICD-9 diagnosis codes that justify the examination on the claim. This policy applies whether the claim is submitted by the provider of the prior examination or by a different provider.

Note: Only two ICD-9 diagnosis codes are acceptable in the *Diagnosis or Nature of Illness or Injury* field (Box 21) of the CMS 1500 claim form. Providers must use separate claim forms when multiple procedures that require diagnosis codes are billed on the same date of service.

### **Required Documentation**

Although many procedure codes can be medically justified with ICD-9 diagnosis codes only, the following CPT-4 codes require further medical justification to be included with the claim for reimbursement.

<b>CPT-4 Code</b>	<b>Description</b>
65210	Removal of foreign body, external eye; conjunctival embedded
67938	Removal of embedded foreign body, eyelid
68761	Closure of the lacrimal punctum
68801	Dilation of the lacrimal punctum
92100	Serial tonometry
92225	Extended ophthalmoscopy
92250	Fundus photography
92310 -	
92312	Contact lens evaluations
92499	Unlisted ophthalmological service or procedure
99205,	
99215	Evaluation and Management
99506	Out-of-Office call

In addition to thoroughly documenting in the medical chart, providers may be required to also submit documentation with the claim indicating the reason additional benefits are warranted when frequency limits are exceeded for all ophthalmological services and eye appliances.

### **Paper Claim Submissions**

Effective for dates of service on or after 7/1/06, the *Payment Request for Vision Care and Appliances* (45-1) claim form will no longer be accepted. All vision services must be billed on the *CMS 1500* claim form.