101 CMR 315.00: RATES FOR VISION CARE SERVICES AND OPHTHALMIC MATERIALS

Section

315.01: General Provisions

(1) Scope. 101 CMR 315.00 governs the rates of payment used by governmental units and purchasers under M.G.L. c. 152, § 1 *et seq*. (the Workers' Compensation Act) for vision-care services and ophthalmic materials provided to publicly aided and industrial accident patients.

(2) Applicable Dates of Service. Rates contained in 101 CMR 315.00 are effective for dates of service on or after February 1, 2023.

(3) Disclaimer of Authorization of Services. 101 CMR 315.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 101 CMR 315.00. Governmental units that purchase care are responsible for the definition, authorization, and approval of care and services provided to publicly aided clients.

(4) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify provisions of 101 CMR 315.00, or to issue coding updates and corrections under 101 CMR 315.01(5).

(5) Coding Updates and Corrections. EOHHS may publish service code updates and corrections in the form of administrative bulletin. Updates may reference coding systems including, but not limited to, the American Medical Association's Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS). The publication of such updates and corrections will list:

(a) codes for which the code numbers change, with the corresponding cross references between the new codes and the codes being replaced. Rates for such updated codes are set at the rate of the code that is being replaced;

(b) codes for which the code numbers remain the same but the description has changed;

(c) deleted codes for which there are no corresponding new codes; and

(d) codes for entirely new services that require pricing. EOHHS will list these codes and apply individual consideration (I.C.) payment for these codes until appropriate rates can be developed.

315.02: General Definitions

The terms used in 101 CMR 315.00 shall have the meanings ascribed in 101 CMR 315.02 and in the CPT Coding Handbook. The descriptions and five-digit procedure codes included in 101 CMR 315.00 are obtained from the American Medical Association's *Current Procedural Terminology* (CPT), copyright 2022, or the 2022 Healthcare Common Procedure Coding System Level II (HCPCS) unless otherwise specified. Both sources provide a listing of descriptive terms and alpha-numeric identifying codes and modifiers for reporting medical services and procedures performed by health-care providers.

Consultation – a type of service provided by a physician or ophthalmologist or optometrist whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or ophthalmologist or optometrist or other appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services. The request for a consultation from the attending physician or ophthalmologist or optometrist or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source. Any specifically identifiable procedure (*i.e.*, identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately. If a consultant subsequently assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used.

(Mass. Register #1486, 1/06/2023)

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Eligible Provider (Provider) – ophthalmologists, optometrists, and dispensing opticians who are registered by an appropriate board of registration in accordance with the provision of M.G.L. c. 112; are not under contractual arrangement with a hospital or affiliated teaching institution for professional services; and who also meet such conditions of participation as may be required by a governmental unit purchasing vision-care services and ophthalmic materials or by purchasers under M.G.L. c. 152.

EOHHS – the Executive Office of Health and Human Services established under M.G.L. c. 6A.

Established Patient – a patient who has received professional services from the physician or ophthalmologist or optometrist within the past three years.

Governmental Unit – the Commonwealth, any department, agency, board, or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Individual Consideration (I.C.) – for service codes for which no rate is listed, the purchaser determines the payment amount on an individual consideration basis upon receipt of a bill that describes the services rendered. The purchaser shall determine the appropriate payment in accordance with the following criteria:

(a) time required to perform the procedure;
(b) degree of skill required for the procedure rendered;
(c) severity and complexity of the patient's disorder or disability;
(d) cost of goods supplied in rendering the service, including catalogue prices of major supplies; and
(e) policies, procedures, and practices of other third-party purchasers of care, governmental and private.

Low Vision – any pathological, traumatic, or congenital condition of the eye or brain that results in reduced visual acuity or reduction of visual field, and that is not amenable to medical, surgical, or ordinary optical correction.

Low-vision Aids – includes, but is not limited to, microscopic and telescopic lenses to correct low vision.

Low-vision Evaluation – a series of evaluative vision tests to measure the degree of low vision and the corrective lenses or aids required.

Modifiers – listed services may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate two-digit number or letters placed after the usual procedure number from which it is separated by a hyphen.

New Patient – a patient who has not received any professional services from the physician or ophthalmologist or optometrist within the past three years.

Ocular Prosthetic Services – the dispensing and adjustment of false eyes.

Publicly Aided Individual – a person for whose medical and other services a governmental unit is in whole or in part liable under a statutory program.

Vision-Care Services and Ophthalmic Materials – professional care of the eye for the purpose of diagnosing and correcting refractive errors and includes the measurement, specification, formulation, construction, and dispensing of eyeglasses and related eye-care appliances.

315.03: General Rate Provisions

(1) Rate Determination. The rates for authorized vision-care services and ophthalmic materials under 101 CMR 315.00 are the lower of

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(a) the provider's usual fee to patients other than publicly aided or industrial accident patients; or
(b) the schedule of allowable fees set forth in 101 CMR 315.04.

(2) Reimbursement as Full Payment. The rates established by 101 CMR 315.00 are full compensation for vision services provided to publicly aided and industrial-accident patients as well as for any related administrative or supervisory duties in connection with the provision of vision-care services without regard to where the services are provided.

(3) Bulk Purchase Contract. If the provider is required by the purchasing governmental unit to order material from designated suppliers under a bulk purchase contract, the provider shall bill the purchasing agency only for the relevant dispensing fee.

315.04: Allowable Fees for Vision-care Services

(1) Modifiers. The following modifiers are used to adjust payments under the circumstances noted in 101 CMR 315.04(1)(a) and (b).

(a) -52 Reduced Services. Modifier -52 is used to describe circumstances in which services provided were reduced in comparison to the full description of the service. When a provider does not complete a procedure in its entirety, such as a provider electing to partially reduce or eliminate a service, the procedure must be billed by appending modifier -52 to the service code. The rate for services billed with modifier -52 is 86% of the rate listed in 101 CMR 315.04(2). For example, modifier -52 would be used for a procedure that includes administration of eyedrops when an optometrist who is not certified to distribute eyedrops, performs the procedure.

(b) Provider Preventable Conditions. The following modifiers are used to report provider preventable conditions in accordance with 42 CFR. 447.26 and result in nonpayment for services.

Modifier	Description
PA	Surgical or other invasive procedure performed on the wrong body part
PB	Surgical or other invasive procedure performed on the wrong patient
PC	Wrong surgical or other invasive procedure performed on a patient

(2) Services and Payments Covered under Other Regulations. Payments for some services performed by ophthalmologists are governed by other EOHHS regulations, including 101 CMR 316.00: *Surgery and Anesthesia*; and 101 CMR 317.00: *Medicine*. The following codes are included in 101 CMR 316.00: 67820, 68761, 68801, 68810, 68811, 68816 and 68840. The following codes are included in 101 CMR 317.00: 92132, 92133, 92134, 92227, 92228, and 92250.

Procedure Code	Rate	Description
76512	$100.44	Ophthalmic ultrasound, diagnostic; B-scan (with or without super-imposed non-quantitative A-scan)
76513	$100.44	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral
76514	$9.31	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
92002	$56.38	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	$72.97	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehen-sive, new patient, one or more visits

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Procedure Code	Rate	Description
92012	$47.22	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	$53.65	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
92015	$13.42	Determination of refractive state
92020	$21.50	Gonioscopy (separate procedure)
92065	$29.35	Orthoptic training
92081	$22.69	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (*e.g.*, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082	$59.74	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (*e.g.*, at least two isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	$87.78	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (*e.g.*, Goldmann visual fields with at least three isopters plotted and static determination within the central 30 degrees or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100	$32.20	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (*e.g.*, diurnal curve or medical treatment of acute elevation of intraocular pressure)
92225	$49.71	Ophthalmoscopy, extended, with retinal drawing (*e.g.*, for retinal detachment, melanoma), with interpretation and report; initial
92226	$45.07	Ophthalmoscopy, extended, with retinal drawing (*e.g.*, for retinal detachment, melanoma), with interpretation and report; subsequent
92229	I.C.	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral
92230	$76.75	Fluorescein angioscopy with interpretation and report
92260	$27.20	Ophthalmodynamometry
92275	$95.32	Electroretinography with interpretation and report
92285	$40.20	External ocular photography with interpretation and report for documentation of medical progress (*e.g.*, close-up photography, slit lamp photography, goniophotography, stereo-photography)
92310	I.C.	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92326	$51.02	Replacement of contact lens
92340	$30.24	Fitting of spectacles, except for aphakia; monofocal
92340 RB	$9.30	Fitting of spectacles, except for aphakia; monofocal (replacement and repair) (per lens)
92341	$37.32	Fitting of spectacles, except for aphakia; bifocal
92341 RB	$13.92	Fitting of spectacles, except for aphakia; bifocal (replacement and repair) (per lens)

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Procedure Code	Rate	Description
92342	$37.32	Fitting of spectacles, except for aphakia; multifocal, other than bifocal
92342 RB	$13.92	Fitting of spectacles, except for aphakia; multifocal, other than bifocal (replacement and repair) (per lens)
92370	$11.76	Repair and refitting spectacles; except for aphakia
92499	I.C.	Unlisted ophthalmological service or procedure
92541	$46.03	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	$40.42	Positional nystagmus test, minimum of four positions, with recording
92544	$31.29	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
99173	$23.65	Screening test of visual acuity, quantitative, bilateral
99202	$52.59	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	$78.42	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	$111.17	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	$140.85	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	$17.03	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
99212	$31.36	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, ten-19 minutes of total time is spent on the date of the encounter.
99213	$43.34	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	$67.85	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

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Procedure Code	Rate	Description
99215	$98.76	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99241	$38.62	Office consultation for a new or established patient, which requires these three key components: A problem focused history; A problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	$59.65	Office consultation for a new or established patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	$76.99	Office consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	$107.34	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	$145.17	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.

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Procedure Code	Rate	Description
99251	$38.20	Inpatient consultation for a new or established patient, which requires these three key components: A problem focused history; A problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.
99252	$61.88	Inpatient consultation for a new or established patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
99253	$91.80	Inpatient consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
99254	$132.27	Inpatient consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.
99304	$49.95	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: A detailed or comprehensive history; A detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	$66.76	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

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Procedure Code	Rate	Description
99306	$85.15	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	$27.53	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, ten minutes are spent at the bedside and on the patient's facility floor or unit.
99308	$43.13	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	$59.40	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	$59.40	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

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Procedure Code	Rate	Description
99328	$71.15	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.
99337	$49.64	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.
99341	$45.98	Home visit for the evaluation and management of a new patient, which requires these three key components: A problem focused history; A problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99342	$67.45	Home visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99343	$97.70	Home visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

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Procedure Code	Rate	Description
99344	I.C.	Home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99347	$35.88	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making; Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99348	$56.41	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99349	$86.60	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
T2002	$9.73	Nonemergency transportation; *per diem*

FRAMES

Procedure Code	Rate	Description
V2020	$58.74	Frames, purchases
V2025	I.C.	Deluxe frame

SINGLE VISION, GLASS OR PLASTIC
If procedure code 92395 is reported, recode with specific lens type below.

Procedure Code	Rate	Description
V2100	$32.47	Sphere, single vision, plano to plus or minus 4.00, per lens
V2101	$34.23	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens

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Procedure Code	Rate	Description
V2102	$48.14	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens
V2103	$28.22	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2104	$31.22	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2105	$34.01	Spherocylinder, single vision, plano to plus orminus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2106	$40.53	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2107	$35.87	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00dcylinder, per lens
V2108	$37.14	Spherocylinder, single vision, plus or minus 4.25d to plus or minus7.00d sphere, 2.12 to4.00d cylinder, per lens
V2109	$41.14	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2110	$41.35	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens
V2111	$42.30	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2112	$46.17	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens
V2113	$53.35	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2114	$56.35	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens
V2115	$61.35	Lenticular (myodisc), per lens, single vision
V2118	$81.07	Aniseikonic lens, single vision
V2121	$70.09	Lenticular lens, per lens, single
V2199	I.C.	Not otherwise classified, single vision lens

BIFOCAL, GLASS OR PLASTIC

Procedure Code	Rate	Description
V2200	$45.85	Sphere, bifocal, plano to plus or minus 4.00d, per lens
V2201	$49.02	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens
V2202	$55.90	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens
V2203	$45.54	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2204	$48.07	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2205	$51.12	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2206	$53.32	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00dcylinder, per lens
V2207	$51.69	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2208	$52.69	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2209	$59.67	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2210	$59.74	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens

315.04: continued

Procedure Code	Rate	Description
V2211	$66.98	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2212	$72.87	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2213	$70.22	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2214	$69.43	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens
V2215	70.48	Lenticular (myodisc), per lens, bifocal
V2218	$111.82	Aniseikonic, per lens, bifocal
V2219	$36.92	Bifocal seg width over 28 mm
V2220	$29.93	Bifocal add over 3.25d
V2221	$87.30	Lenticular lens, per lens, bifocal
V2299	I.C.	Specialty bifocal (by report)

TRIFOCAL, GLASS OR PLASTIC

Procedure Code	Rate	Description
V2300	$59.98	Sphere, trifocal, plano to plus or minus 4.00d, per lens
V2301	$81.52	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens
V2302	$90.66	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens
V2303	$60.45	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2304	$62.03	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens
V2305	$77.30	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens
V2306	$74.82	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2307	$81.46	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2308	$83.90	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2309	$95.82	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2310	$81.12	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2311	$93.16	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2312	$99.05	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2313	$107.95	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2314	$89.13	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens
V2315	$131.92	Lenticular, (myodisc), per lens, trifocal
V2318	$162.19	Aniseikonic lens, trifocal
V2319	$44.12	Trifocal seg width over 28 mm
V2320	$43.43	Trifocal add over 3.25d
V2321	$128.81	Lenticular lens, per lens, trifocal
V2399	I.C.	Specialty trifocal (by report)

315.04: continued

VARIABLE ASPHERICITY

Procedure Code	Rate	Description
V2410	$74.34	Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430	$91.37	Variable asphericity lens, bifocal, full field, glass or plastic, per lens
V2499	I.C.	Variable sphericity lens, other type

CONTACT LENSES
If procedure code 92396 is reported, recode with specific lens type listed below (per lens).

Procedure Code	Rate	Description
V2500	$70.67	Contact lens, PMMA, spherical, per lens
V2501	$136.89	Contact lens, PMMA, toric or prism ballast, per lens
V2502	$166.01	Contact lens PMMA, bifocal, per lens
V2503	$155.31	Contact lens, PMMA, color vision deficiency, per lens
V2510	$105.02	Contact lens, gas permeable, spherical, per lens
V2511	$176.28	Contact lens, gas permeable, toric, prism ballast, per lens
V2512	$184.70	Contact lens, gas permeable, bifocal, per lens
V2513	$149.65	Contact lens, gas permeable, extended wear, per lens
V2520	$49.46	Contact lens, hydrophilic, spherical, per lens
V2521	$75.96	Contact lens, hydrophilic, toric, or prism ballast, per lens
V2522	$93.26	Contact lens, hydrophilic, bifocal, per lens
V2523	$78.38	Contact lens, hydrophilic, extended wear, per lens
V2530	I.C.	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, *see* 92325)
V2531	I.C.	Contact lens, scleral, gas permeable, per lens (for contact lens modification, *see* 92325)
V2599	I.C.	Contact lens, other type

LOW-VISION AIDS
If procedure code 92392 is reported, recode with specific systems listed below.

Procedure Code	Rate	Description
V2600	I.C.	Hand held low vision aids and other nonspectacle mounted aids
V2610	I.C.	Single lens spectacle mounted low vision aids
V2615	I.C.	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system

PROSTHETIC EYE

Procedure Code	Rate	Description
V2623	I.C.	Prosthetic eye, plastic, custom
V2624	I.C.	Polishing/resurfacing of ocular prosthesis
V2625	I.C.	Enlargement of ocular prosthesis
V2626	I.C.	Reduction of ocular prosthesis
V2627	I.C.	Scleral cover shell
V2628	I.C.	Fabrication and fitting of ocular conformer
V2629	I.C.	Prosthetic eye, other type

315.04: continued

INTRAOCULAR LENSES

Procedure Code	Rate	Description
V2630	I.C.	Anterior chamber intraocular lens
V2631	I.C.	Iris supported intraocular lens
V2632	I.C.	Posterior chamber intraocular lens

MISCELLANEOUS

Procedure Code	Rate	Description
V2700	$38.07	Balance lens, per lens
V2710	$53.15	Slab off prism, glass or plastic, per lens
V2715	$9.62	Prism, per lens
V2718	$30.62	Press-on lens, Fresnel prism, per lens
V2730	$17.92	Special base curve, glass or plastic, per lens
V2744	$13.60	Tint, photochromatic, per lens
V2745	$8.45	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens
V2750	$15.82	Antireflective coating, per lens
V2755	$18.35	U-V lens, per lens
V2760	$13.98	Scratch resistant coating, per lens
V2770	$21.58	Occluder lens, per lens
V2780	$11.38	Oversize lens, per lens
V2781	I.C.	Progressive lens, per lens
V2785	I.C.	Processing, preserving and transporting corneal tissue
V2788	I.C.	Presbyopia correcting function of intraocular lens
V2799	I.C.	Vision item or service, miscellaneous

315.05: Severability

The provisions of 101 CMR 315.00 are severable, and if any provision of 101 CMR 315.00 or application of such provision to any eligible provider of vision-care services and ophthalmic materials or any circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 315.00 or application of such provisions to eligible providers of vision-care services and ophthalmic materials or circumstances other than those held invalid.

REGULATORY AUTHORITY

101 CMR 315.00: M.G.L. c. 118E

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