Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER VIS-32
December 2002

TO: Vision Care Providers Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *Vision Care Manual* (Age Limitations for Certain Vision Care Services and Revisions to Service Codes and Descriptions)

Beginning January 1, 2003, age restrictions have been added to certain vision care services. The Division's current budget appropriation requires these changes, at a minimum, to cover expected deficiencies.

This letter transmits revisions to the *Vision Care Manual* Subchapter 4, Program Regulations, at 130 CMR 402.000 and Subchapter 6, Service Codes and Descriptions. These revisions are effective for dates of service on or after January 1, 2003. Subchapter 5, Billing Instructions, will be revised and sent under separate cover.

I. Age Limitations for Certain Vision Care Services

Effective January 1, 2003, the Division will cover the following vision care services only when provided to eligible MassHealth members under age 21: ophthalmic materials, specifically including, but not limited to, complete eyeglasses or eyeglass parts; the dispensing of ophthalmic materials; contact lenses; and other visual aids, except that this age limitation will not apply to visual magnifying aids for use by members who are both diabetic and legally blind. Visual magnifying aids do not include eyeglasses or contact lenses. As of January 1, 2003, you should inform MassHealth members aged 21 and older that MassHealth no longer covers these services.

Vision examination and testing services will continue to be covered for all MassHealth members. **The changes to the regulations do not alter vision care services for members under age 21.**

A. Service-Specific Prior Authorizations Approved or Appealed Prior to January 1, 2003

If MassHealth approved a prior-authorization (PA) request for a member aged 21 and older on or before October 25, 2002 and the request was for any of the services listed above, MassHealth will continue to pay for those services through the authorized period. Until December 31, 2002, MassHealth will approve medically necessary PA requests for members aged 21 and older for a 90-day period from the date the PA request is approved or changed. After December 31, 2002, MassHealth will no longer approve PA requests for members aged 21 and older for the services listed above.

If a member appeals any prior-authorization decision made prior to January 1, 2003, the Division will pay for the service if the Board of Hearings or a court does not uphold the Division's decision.

B. Claims for Custom-Made Goods

The Division will pay for custom-made goods in the following circumstances for dates of service after January 1, 2003:

- custom-made goods started before January 1, 2003, but not completed until after; and
- custom-made goods where the prior-authorization expiration date is after January 1, 2003.

As stated in 130 CMR 450.231(B), "the 'date of service' is the date on which a medical service is furnished to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers medical goods to a member, which goods had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date prior to the final delivery of the goods, the Division will reimburse the provider for the goods..."

Providers must submit paper claims for these services with all applicable documentation as outlined in 130 CMR 450.231(B) to the following address.

Division of Medical Assistance
Claims Operations Unit 6
Attention: After Cancel Unit
600 Washington Street
Boston, MA 02111

C. Prior-Authorization Requests for Visual Magnifying Aids for Members Aged 21 and Older

As of January 1, 2003, visual magnifying aids for MassHealth members aged 21 and older who are both diabetic and legally blind can be billed using Service Codes V2600, V2610, V2615, and V2799. These service codes require prior authorization.

Prior-authorization requests for visual magnifying aids for members aged 21 and older must clearly state that the member is diabetic and legally blind.

Effective for dates of service on or after January 1, 2003, any claims for visual magnifying aids for members aged 21 and older who are both diabetic and legally blind must contain the ICD-9-CM diagnosis code. To ensure that your claims for visual magnifying aids for these members are appropriately identified, enter an ICD-9-CM diagnosis code that accurately describes the member's condition in Items 21 and 23 of claim form no. 9, and the corresponding diagnosis name in Items 22 and 24.

II. Revised Subchapter 6, Service Codes and Descriptions

The Centers for Medicare and Medicaid Services (CMS) have revised the Healthcare Common Procedure Coding System (HCPCS) for 2002. New national service codes have been added, and MassHealth local codes have been removed from the *Vision Care Manual*. Please note that you must use a modifier with some codes to accurately reflect the service provided. The attached Subchapter 6 contains codes with modifiers, where applicable.

A. Billing for Dispensing Using the New Service Codes

Effective for dates of service on or after February 1, 2003, billing for the dispensing of vision care materials has been simplified. All applicable MassHealth local codes have been replaced with standard CPT codes.

Providers will no longer need to bill two separate dispensing fees when dispensing a pair of eyeglasses, or have separate service codes for a single lens and a pair of lenses. When dispensing an entire new pair of eyeglasses, providers will bill a single service code – 92340, 92341, or 92342 – depending on the type of eyeglasses provided. Dispensing fees for replacement frames alone or frame parts have been bundled together under a single service code, 92370. Dispensing fees for lenses alone will be billed per lens, under the code with modifier combination appropriate to those lenses (single vision, bifocal, or multifocal other than bifocal).

B. Converting From Obsolete Service Codes to New Service Codes

Please see the attached revised Subchapter 6 for complete information on applicable codes and modifiers.

Please find attached a crosswalk from the obsolete MassHealth local service codes and modifiers to the new national service codes and modifiers for the revised Subchapter 6.

C. Prior-Authorization Transition Period

Effective for dates of service on or after February 1, 2003, all requests for prior authorization (PA) must be submitted using the new national service codes from the revised Subchapter 6.

Providers who have already requested PA, and who have received approval for vision care services under the old local code system, may continue to bill for dates of service on or after February 1, 2003, using the existing PA number under which they have been granted approval. **However, local codes will not be accepted on claims for dates of service on or after February 1, 2003.** Providers, therefore, must bill using the new national service codes from the revised Subchapter 6 that correspond to the local code services that have been approved under the existing PA.

Providers are not required to do anything to convert their approved PA numbers due to the MassHealth transition to national service codes.

D. How to Obtain a Vision Care Services Fee Schedule with the New Service Codes

If you wish to obtain a fee schedule with the new procedure codes, you may purchase Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). You must contact them first to find out the price of the publication. The Division of Health Care Finance and Policy also has the regulations available on disk. The regulation title is 114.3 CMR 15.00: Vision Care Services.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

III. Web Site Access and Questions

This transmittal letter and the revised regulations are available on the Division's Web site at www.mass.gov/dma.

If you have any questions, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Vision Care Manual

Pages vi, 4-1 through 4-4, 4-7, 4-8, and 6-1 through 6-10

OBSOLETE MATERIAL

Vision Care Manual

Page vi, 4-1, 4-2, 4-7, and 4-8 — transmitted by Transmittal Letter VIS-30

Page 4-3 and 4-4 — transmitted by Transmittal Letter VIS-31

Pages 6-1 through 6-8 — transmitted by Transmittal Letter VIS-26

Pages 6-9 and 6-10 — transmitted by Transmittal Letter VIS-28

Vision Care Provider
Service Code Crosswalk

Old code	Along with	Description	New code	Modifier	Description	Unit
X1040		Frame dispensing fee when placing new lens or lenses into member's existing contract frame	92370		Repair and refitting spectacles; except for aphakia	Included in payment for repair
X8042		Dispensing fee for 2nd pair of single vision glass/plastic lenses and frame instead of bifocals	92340		Fitting of spectacles, except for aphakia; monofocal	2nd pair
X8050		Lens dispensing fee for replacement of single vision lens or lenses for insertion into contract frame (each lens)	92340-RP	replacement and repair	Fitting of spectacles, except for aphakia; monofocal	per lens
X8051	X8070	Dispensing fee for complete new frame + Dispensing fee for any pair of single vision glass/plastic lenses	92340		Fitting of spectacles, except for aphakia; monofocal	1 (includes frame and pair of lenses)
X8051	X8071	Dispensing fee for complete new frame + Dispensing fee for bifocal glass/plastic lenses *(if dispensed bifocal lenses)*	92341		Fitting of spectacles, except for aphakia; bifocal	1 (includes frame and pair of lenses)
X8051	X8071	Dispensing fee for complete new frame + Dispensing fee for bifocal glass/plastic lenses *(if dispensed multifocal lenses other than bifocal)*	92342		Fitting of spectacles, except for aphakia; multifocal other than bifocal	1 (includes frame and pair of lenses)
X8052		Dispensing fee for frame front only	92370		Repair and refitting spectacles; except for aphakia	1
X8053		Dispensing fee for frame temples, hinges, and pads only	92370		Repair and refitting spectacles; except for aphakia	1
X8054		Dispensing fee for single vision plastic cataract lenses, per pair	92340-RP	replacement and repair	Fitting of spectacles, except for aphakia; monofocal	per lens (= 2)
X8056		Dispensing fee for bifocal plastic cataract lenses, per pair *(if dispensed bifocal lenses)*	92341-RP	replacement and repair	Fitting of spectacles, except for aphakia; bifocal	per lens (= 2)
X8056		Dispensing fee for bifocal plastic cataract lenses, per pair *(if dispensed multifocal lenses other than bifocal)*	92342-RP	replacement and repair	Fitting of spectacles, except for aphakia; multifocal other than bifocal	per lens (= 2)
X8057		Dispensing fee for replacement of a broken frame	92370		Repair and refitting spectacles; except for aphakia	1
X8058		Lens dispensing fee for replacement of bifocal lens or lenses for insertion into contract frame (each lens) *(if dispensed bifocal lens)*	92341-RP	replacement and repair	Fitting of spectacles, except for aphakia; bifocal	per lens

Old code	Along with	Description	New code	Modifier	Description	Unit
X8058		Lens dispensing fee for replacement of bifocal lens or lenses for insertion into contract frame (each lens) *(if dispensed multifocal lens other than bifocal)*	92342-RP	replacement and repair	Fitting of spectacles, except for aphakia; multifocal other than bifocal	per lens
X8059		Lens dispensing fee for replacement of single vision cataract lens or lenses for insertion into contract frame (each lens)	92340-RP	replacement and repair	Fitting of spectacles, except for aphakia; monofocal	per lens
X8060		Lens dispensing fee for replacement of bifocal cataract lens or lenses for insertion into contract frame (each lens) *(if dispensed bifocal lens)*	92341-RP	replacement and repair	Fitting of spectacles, except for aphakia; bifocal	per lens
X8060		Lens dispensing fee for replacement of bifocal cataract lens or lenses for insertion into contract frame (each lens) *(if dispensed multifocal lens other than bifocal)*	92342-RP	replacement and repair	Fitting of spectacles, except for aphakia; multifocal other than bifocal	per lens
X8061		Low-vision evaluation	99205		Complex E/M (for complex eye exam)	
X9335		Titmus vision test	99173		Screening test of visual acuity, quantitative, bilateral	
X9343		Optometrist/optician home/nursing facility visit for the pickup of a new prescription and fitting of new eyeglasses, or for the delivery and adjustment of new eyeglasses, or for the pickup of broken eyeglasses, or for the delivery of repaired eyeglasses (payable for first recipient seen only; not payable for additional recipients seen during the same visit)	T2002		Non-emergency transportation; *per diem*	
-YX		Eye exams performed without cycloplegic or mydriatic drops		-52	Reduced Services	
-YZ		Vision care services, each additional nursing home patient		Modifier deleted, no longer in use		

6. SERVICE CODES AND DESCRIPTIONS

402.401: Introduction

(A) The regulations in 130 CMR 402.000 state the requirements and procedures for the purchase of vision care services under MassHealth. Vision care services are the professional care of the eyes for purposes of diagnosing and correcting refractive errors, analyzing muscular anomalies, and determining pathological conditions. They include eye examinations, vision training, and the prescription and dispensing of ophthalmic materials. Professional and technical services must be provided in accordance with the established standards of quality and health-care necessity recognized by the vision care industry and licensing agencies in Massachusetts.

(B) All vision care providers participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations set forth in 130 CMR 402.000 and 450.000.

402.402: Definitions

The following terms used in 130 CMR 402.000 shall have the meanings given in 130 CMR 402.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 402.402 is not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 402.000 and in 130 CMR 450.000.

Dispensing Practitioner — any optician, optometrist, ophthalmologist, or other participating provider authorized by the Division to dispense eyeglass frames, lenses, and other vision care materials to members.

Optical Supplier — the optical laboratory contracted by the Division to supply the following ophthalmic materials and services:

(1) eyeglass frames;
(2) eyeglass lenses;
(3) frame cases;
(4) tints, coatings, ground-on prisms, and prisms by decentration; and
(5) repair parts.

Order — the process by which a dispensing practitioner requests ophthalmic materials (completed eyeglasses, repair parts, and other services) from the optical supplier.

Order Form — the form used by the dispensing practitioner to request ophthalmic materials (completed eyeglasses, repair parts, and other services) from the optical supplier. The required form is specified in the billing instructions in Subchapter 5 of the *Vision Care Manual.*

Prescriber — any optometrist, ophthalmologist, or other practitioner licensed and authorized to write prescriptions for eyeglass frames, lenses, and other vision care services.

402.403: Eligible Members

(A) (1) MassHealth Members. The Division covers vision care services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Age Limitations. In addition to any other restrictions and limitations set forth in 130 CMR 402.000 and 450.000, the Division covers the following services only when provided to eligible MassHealth members under age 21: ophthalmic materials, specifically including, but not limited to, complete eyeglasses or eyeglass parts; the dispensing of ophthalmic materials; contact lenses; and other visual aids, except that this age limitation does not apply to visual magnifying aids for use by members who are both diabetic and legally blind. Visual magnifying aids do not include eyeglasses or contact lenses.

(3) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

402.404: Provider Eligibility

Payment for services described in these regulations will be made only to providers of vision care services who are participating in MassHealth on the date of service. The eligibility requirements for providers of vision care services are as follows.

(A) In State.

(1) Optometrists. A Massachusetts optometrist is eligible to participate in MassHealth only if licensed to practice by the Massachusetts Board of Registration of Optometrists.

(a) A Level I optometrist is one who is not qualified to apply topical agents.

(b) A Level II optometrist is one who has completed the required course of study and passed the examination necessary to obtain certification to apply topical agents.

(c) A Level III optometrist is one who is certified to prescribe, dispense, and administer therapeutic pharmaceutical agents (TPA) for abnormal ocular conditions and diseases.

(2) Opticians. A Massachusetts optician is eligible to participate in MassHealth only if licensed to practice by the Massachusetts Board of Registration of Opticians.

(3) Ophthalmologists. A Massachusetts ophthalmologist is eligible to participate in MassHealth only if licensed to practice by the Massachusetts Board of Registration in Medicine. Ophthalmologists are governed by these regulations only with respect to the dispensing of ophthalmic materials. All other vision care services provided by ophthalmologists must be in compliance with the physician regulations of MassHealth.

(4) Ocularists. A Massachusetts ocularist is eligible to participate in MassHealth only if certified by the National Examining Board of Ocularists.

(B) Out of State.

(1) Optometrists. An optometrist located outside of Massachusetts is eligible to receive payment for vision care services provided to Massachusetts members only if the optometrist is licensed to practice by the appropriate state's board of registration.

(2) Opticians. An optician located outside of Massachusetts is eligible to receive payment for vision care services provided to MassHealth members only if the optician is licensed to practice by the appropriate state's board of registration.

(3) Ophthalmologists. An ophthalmologist located outside of Massachusetts is eligible to receive payment for vision care services provided to MassHealth members only if the ophthalmologist is licensed to practice by the appropriate state's board of registration. Ophthalmologists are governed by these regulations only with respect to the dispensing of ophthalmic materials. All other vision care services provided by ophthalmologists must be in compliance with the physician regulations of MassHealth.

(4) Ocularists. An ocularist located outside of Massachusetts is eligible to receive payment for vision care services provided to MassHealth members only if the ocularist has been certified by the National Examining Board of Ocularists.

402.405: Nonreimbursable Circumstances

Vision care services are not reimbursable to a vision care provider when the services were furnished in a state institution, in a hospital, or in a hospital-affiliated teaching institution, and when the services are among those for which the provider is compensated by the state or institution.

402.406: Maximum Allowable Fees

The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for all vision care services and ophthalmic materials, except for those ophthalmic materials purchased through the optical supplier where the basis for the rates is set by the terms of the contract. Payment is always subject to the conditions, exclusions, and limitations set forth in these regulations. The payment for a service will be the lower of the following:

(A) the provider's usual and customary fee; or

(B) the maximum allowable fee listed in the applicable DHCFP fee schedule.

402.407: Individual Consideration

Some services listed in Subchapter 6 of the *Vision Care Manual* are designated "I.C.," an abbreviation for individual consideration. Individual consideration means that a fee could not be established. The payment for an individual-consideration service will be determined by the Division's professional advisors from the provider's descriptive report of the service furnished.

402.408: Prior Authorization

(A) For certain services specified in 130 CMR 402.426 through 402.434, the Division requires that the provider of the service obtain prior authorization as a prerequisite to payment. In addition, services that are designated in Subchapter 6 of the *Vision Care Manual* by the abbreviation "P.A." require prior authorization. These services include but are not limited to:

(1) certain contact lenses;
(2) low-vision aids;
(3) fundus photographs;
(4) unlisted services;
(5) glass lenses;
(6) special-needs glasses;
(7) polycarbonate lenses, except for members who are under age 21 or who are amblyopic or monocular; and
(8) vision training.

(B) Prior authorization requests for low-vision aids for members aged 21 and older must contain a clear statement that the member is diabetic and legally blind.

(C) All prior-authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Vision Care Manual*. Prior authorization determines only the health-care necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

402.409: Separate Procedure

Some procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it is designated as a "separate procedure" or "S.P." in the service description. Thus, when a procedure is performed alone for a specific purpose, it must be considered a separate procedure.

(130 CMR 402.410 through 402.415 Reserved)

(D) All screening services must be fully documented in the member's record. A record for a screening service must note the chief complaint and must contain all findings of two or more of the following tests:

(1) distance vision and near vision;
(2) cover test;
(3) visual skills;
(4) tonometry; and
(5) biomicroscopy.

402.418: Services Provided Outside the Office

(A) Member's Home. The Division will pay for vision care services provided to a member in the member's home. A health-care record must be kept on file at the provider's office.

(B) Nursing Facility. The Division will pay an optometrist or an ophthalmologist for performing an eye examination for a member residing in a nursing facility only when the optometrist or ophthalmologist is specifically requested to do so by the medical director, the nursing director, or responsible staff member at the facility, or the member's personal physician. The request must be documented in the member's record at the facility. If eyeglasses are to be dispensed to a member in the facility, the facility must document in the member's record that a consultation has occurred between the facility's staff member and the optometrist or ophthalmologist, and that they have determined that the member is able to benefit from eyeglasses. A copy of the eye-examination results, including the prescription, must be filed in the member's record at the facility and at the optometrist's or ophthalmologist's office.

(C) Other Facilities. The Division will pay for vision care services provided to a member residing in a public or private facility, if payment for these services is not included in the facility's rate. A health-care record must be kept on file at the provider's office.

(D) Claims for Payment.

(1) A visual analysis performed for a member in the member's home, a nursing facility, or another facility must be claimed using the appropriate service codes. (See Subchapter 6 of the *Vision Care Manual*).

(2) The Division will pay once per facility per date of service for the following services: the delivery and adjustment of eyeglasses; the pickup of broken eyeglasses; or the delivery of repaired eyeglasses.

(130 CMR 402.419 through 402.425 Reserved)

402.426: Service Limitations: Visual Analysis

(A)(1) The Division will not pay for a comprehensive eye examination in an optometrist's office or a visual analysis in a home or nursing facility if a comprehensive eye examination or a visual analysis has been furnished:

(a) within the preceding 12 months, for a member under the age of 21; or

(b) within the preceding 24 months, for a member aged 21 or older.

(2) These restrictions do not apply if there is a referral from the member's physician or if one of the following complaints or conditions is documented in the member's record:

(a) blurred vision;

(b) evidence of headaches;

(c) systemic diseases such as diabetes, hyperthyroidism, or HIV;

(d) cataracts;

(e) pain;

(f) redness; or

(g) infection.

(B) The Division will pay for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) The Division will not pay for a screening service if two screening services have been furnished to the member within the preceding 12 months.

(D) A comprehensive eye examination includes a screening service. If the provider performs both a screening service and a comprehensive eye examination for the same member, the Division will pay for only the comprehensive eye exam.

(E) The Division will not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, a consultation, or a screening service. When a tonometry is performed as a separate service to monitor a member who has glaucoma, the provider must use the appropriate service code (see Subchapter 6 of the *Vision Care Manual*).

402.427: Service Limitations: Time and Power Restrictions on Dispensing Eyeglasses

(A) The Division will pay for only one initial pair of eyeglasses and only if there is a corrective power of at least ±.75D sphere or ±.50D cylinder. (See 130 CMR 402.431 for an exception permitting two pairs of eyeglasses instead of bifocals.)

(B) The Division will pay for the replacement of a pair of lost or stolen eyeglasses only if there is a corrective power of at least ±.75D sphere or ±.50D cylinder, and only if the lost or stolen eyeglasses were not dispensed within the preceding 12 months.

(C) The Division will pay for a subsequent pair of lenses only if there is a change from the current prescription of at least ±.50D sphere or cylinder; or an axis change of at least 3º for a ±1.00D cylinder or over, 5º for a ±.75D cylinder, or 10º for a ±.50D cylinder.

601 Definitions

The following terms used in Subchapter 6 shall have the meanings given below.

(A) Consultation — a type of service provided by a physician or an optometrist whose opinion or advice regarding evaluation or management of a specific problem is requested by a physician, optometrist, or other appropriate source.

(1) A physician consultant may initiate diagnostic or therapeutic services, or both.

(2) The request for a consultation from the attending physician, 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.

(3) Any procedure identified with a specific CPT code and 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.

(B) Established Patient — a patient who has received professional services from a physician or an optometrist within the past three years.

(C) Evaluation and Management (E/M) Services — a new way of classifying the work of physicians and optometrists. In particular, E/M services involve far more clinical detail than the old visit codes. The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For a full discussion of these services, refer to the current CPT handbook.

(D) New Patient — a patient who has not received any professional services from a physician or an optometrist within the past three years.

(E) Ophthalmological Service Levels

(1) Intermediate Services — a level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination, and other diagnostic procedures as indicated; may include the use of mydriasis. Intermediate services do not usually include determination of the refractive state but may do so in an established patient who is under continuing active treatment. For example:

601 Definitions (cont.)

(a) review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (for example, iritis) not requiring comprehensive ophthalmological services; and

(b) review of interval history, external examination, ophthalmoscopy, biomicroscopy, and tonometry in an established patient with a known cataract not requiring comprehensive ophthalmological services.

(2) Extended Services — a level of service requiring an unusual amount of effort or judgment, including a detailed history, review of medical records, examination, and a formal conference with patient, family, or staff, or a comparable medical diagnostic and/or therapeutic service.

(3) Comprehensive Services — a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields, and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis, and tonometry. It always includes initiation of diagnostic and treatment programs as indicated. For example: the comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient.

602 Explanation of Abbreviations

The following abbreviations are used in Subchapter 6.

(A) I.C. indicates that the claim will receive individual consideration to determine payment (see 130 CMR 402.407).

(B) P.A. indicates that prior authorization is required (see 130 CMR 402.408).

(C) S.P. indicates that the procedure is commonly performed as part of a total service and does not usually warrant a separate fee. The procedure must be performed separately to receive the separate fee. (See 130 CMR 402.409.)

603 Service Codes and Descriptions: Visual Analysis

When billing for eye examinations performed without cycloplegic or mydriatic drops or for additional patients seen in a nursing facility, use the modifier 52 (reduced services).

Service Code	Service Description

OFFICE OR OTHER OUTPATIENT SERVICES

New Patient

99201	Office or other outpatient 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
99202	Office or other outpatient 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 - straightforward medical decision making
99203	Office or other outpatient 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 low complexity
99204	Office or other outpatient 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
99205	Office or other outpatient 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

603 Service Codes and Descriptions: Visual Analysis (cont.)

Service Code	Service Description
	Established Patient
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a problem-focused history; - a problem-focused examination; - straightforward medical decision making
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; - medical decision making of low complexity
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a detailed history; - a detailed examination; - medical decision making of moderate complexity
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a comprehensive history; - a comprehensive examination; - medical decision making of high complexity
	Ophthalmological Services Provided During an Office Visit, New or Established Patient
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	comprehensive, established patient, one or more visits
92015	Determination of refractive state

603 Service Codes and Descriptions: Visual Analysis (cont.)

Service Code	Service Description

CONSULTATIONS

99241	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
99242	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
99243	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
99244	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
99245	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
99251	Initial 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

NURSING FACILITY SERVICES

Comprehensive Nursing Facility Assessments (New or Established Patient)

The following codes are to be used for services delivered in a nursing facility, home, or other facility.

99301	Evaluation and management of a new or established patient involving an annual nursing facility assessment, which requires these three key components: - a detailed interval history; - a comprehensive examination; and - medical decision making that is straightforward or of low complexity

603 Service Codes and Descriptions: Visual Analysis (cont.)

Service Code	Service Description
99302	Evaluation and management of a new or established patient involving a nursing facility assessment, which requires these three key components: - a detailed interval history; - a comprehensive examination; and - medical decision making of moderate to high complexity
99303	Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate-to-high complexity
99313	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: - a detailed interval history; - a detailed examination; - medical decision making of moderate-to-high complexity
99323	Domiciliary or rest 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 high complexity
99333	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 detailed interval history; - a detailed examination; - medical decision making of high complexity
T2002	Non-emergency transportation; per diem (use for optometrist/optician home/nursing facility visit for the pickup of a new prescription and fitting of new eyeglasses, or for the delivery and adjustment of new eyeglasses, or for the pickup of broken eyeglasses, or for the delivery of repaired eyeglasses; payable for first recipient seen only, not payable for additional recipients seen during the same visit)

604 Service Codes and Descriptions: Supplementary Testing

Service Code	Service Description
76512	Ophthalmic ultrasound, echography, diagnostic; contact B-scan (with or without simultaneous A-scan) (professional component only) (Level II optometrists only)
76513	anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy (professional component only) (Level II optometrists only)
92020	Gonioscopy (separate procedure) (Level II optometrists only) (S.P.)

604 Service Codes and Descriptions: Supplementary Testing (cont.)

Service Code	Service Description
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation (P.A.)
92081	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	intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30º, 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	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) (S.P.)
92120	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method (Level II optometrists only)
92130	Tonography with water provocation (Level II optometrists only)
92140	Provocative tests for glaucoma, with interpretation and report, without tonography (Level II optometrists only)
92225	Ophthalmoscopy, extended with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial (Level II optometrists only)
92226	subsequent (Level II optometrists only)
92250	Fundus photography with interpretation and report (P.A.) (Both eyes equal one unit.)
92260	Ophthalmodynamometry (Level II optometrists only)
92275	Electroretinography with interpretation and report (Level II optometrists only)
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording (Level II optometrists only)
92542	Positional nystagmus test, minimum of four positions, with recording (Level II optometrists only)
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording (Level II optometrists only)
99173	Screening test of visual acuity, quantitative, bilateral (use for titmus vision test)

605 Service Codes and Descriptions: Contact Lenses

Service Code	Service Description
V2500	Contact lens, PMMA, spherical, per lens
V2501	Contact lens, PMMA, toric or prism ballast, per lens (I.C.)
V2503	Contact lens, PMMA, color vision deficiency, per lens (P.A.) (I.C.)
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, per lens (P.A.) (I.C.)
V2512	Contact lens, gas permeable, bifocal, per lens (P.A.) (I.C.)
V2520	Contact lens, hydrophilic, spherical, per lens
V2521	Contact lens, hydrophilic, toric or prism ballast, per lens (P.A.) (I.C.)
V2522	Contact lens, hydrophilic, bifocal, per lens (P.A.) (I.C.)
V2599	Contact lens, other type (P.A.) (I.C.)

606 Service Codes and Descriptions: Contact Lens Services

Service Code	Service Description
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 (I.C.)
92326	Replacement of contact lens

607 Service Codes and Descriptions: Fitting of Prescription Spectacles, Glass/Plastic Lenses

Service Code	Service Description
92340	Fitting of spectacles, except for aphakia; monofocal (use for dispensing entire new initial eyeglasses, or entire new replacement eyeglasses)
92341	bifocal (use for dispensing entire new initial eyeglasses, or entire new replacement eyeglasses)
92342	multifocal, other than bifocal (use for dispensing entire new initial eyeglasses, or entire new replacement eyeglasses)

608 Service Codes and Descriptions: Repairs and Replacement Parts

Service Code-Modifier	Service Description
92340-RP	Fitting of spectacles, except for aphakia; monofocal – **Replacement and repair** (use for dispensing replacement single vision lens, glass or plastic, including cataract lenses, per lens)
92341-RP	bifocal – **Replacement and repair** (use for dispensing replacement bifocal lens, glass or plastic, including cataract lenses, per lens)
92342-RP	multifocal, other than bifocal – **Replacement and repair** (use for dispensing replacement multifocal lens, other than bifocal, glass or plastic, including cataract lenses, per lens)
92370	Repair and refitting spectacles; except for aphakia (use for dispensing replacement frame only, replacement frame components such as hinges or temples, or replacing lenses into a member's existing contract frame)

609 Service Codes and Descriptions: Miscellaneous

Service Code	Service Description
V2600	Hand-held low-vision aids and other nonspectacle-mounted aids (P.A.) (I.C.)
V2610	Single-lens spectacle-mounted low-vision aids (P.A.) (I.C.)
V2615	Telescopic and other compound lens system, including distance vision telescopic, near visiontelescopes, and compound microscopic lens system (P.A.) (I.C.)
V2623	Prosthetic eye, plastic, custom (I.C.)
V2624	Polishing/resurfacing of ocular prosthesis (I.C.)
V2625	Enlargement of ocular prosthesis (I.C.)
V2626	Reduction of ocular prosthesis (I.C.)
V2627	Scleral cover shell (I.C.)
V2628	Fabrication and fitting of ocular conformer (I.C.)
V2629	Prosthetic eye, other type (P.A.) (I.C.)
V2799	Vision service, miscellaneous (P.A.) (I.C.)

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