601 Introduction

MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 402.000 and 450.000. A vision care provider may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. §§ 1396d(a)(4)(B), and 42 U.S.C. § 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in Subchapter 6 of the *Vision Care Manual*.

602 Definitions

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

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

(1) A 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 after the date of the initial consultation should be reported separately. If a consultant subsequently assumes responsibility for management of a portion or all the patient's conditions, the consultation codes should not be used.

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

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

(D) 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:

(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.

602 Definitions (Cont.)

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 does not have to 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.

603 Explanation of Abbreviations

The following abbreviations are used in Subchapter 6.

(A) "IC" indicates that the claim will receive individual consideration to determine payment. See regulations at 130 CMR 402.407.

(B) "PA" indicates that prior authorization is required. See 130 CMR 402.408.

(C) "SP" is an abbreviation for separate procedure and indicates that the procedure is commonly performed as an integral part of a total service and, as such, does not usually warrant a separate fee. The procedure must be performed alone for a specific purpose to receive the separate fee. See regulations at 130 CMR 402.409.

604 Payable CPT Codes: Visual Analysis

Use Modifier 52 (reduced services) when billing for eye examinations performed without cycloplegic or mydriatic drops.

99202	99212	99305	99310
99203	99213	99306	
99204	99214	99307	
99205	99215	99308	
99211	99304	99309	

605 Payable CPT Codes: Home Services

99341	99344	99348
99342	99347	99349

606 Payable CPT Codes: Procedures

65205	76514	92083	92250
65210	92002	92100 (SP)	92260
65222	92004	92132	92273
65778	92012	92133	92274
67820	92014	92134	92285
68761	92015	92201	92541
68801	92020 (SP)	92202	92542
68840	92065 (PA)	92227	92544
76512	92081	92228	
76513	92082	92229	

607 Payable CPT Codes: Contact Lenses

92310 (IC)	V2500	V2503 (PA)	V2511 (PA)
92326	V2501	V2510	

Codes in the section below can only be billed once per lens order per eye.

V2512 (PA)	V2521 (PA)	V2599 (PA)(IC)
V2520	V2522 (PA)	

608 Payable CPT Codes: Spectacles; Fitting/Dispensing

92340
92340-RB
92341
92341-RB
92342
92342-RB

92370 Repair and re-fitting or re-dispensing spectacles; except for aphakia (use for fitting or dispensing a replacement frame only, or any replacement frame components such as hinges or temples)

609 Payable CPT Codes: Miscellaneous

99173
99174
99177
T2002 Nonemergency transportation, per diem (once per member per date of service for each member for whom the provider delivered or picked up eyeglasses, or to whom vision care services were provided out of the office)

V2600 (PA)(IC)
V2610 (PA)(IC)
V2615 (PA)(IC)
V2799 (PA)(IC)

610 Payable CPT Codes**:** Miscellaneous – Ocularists Only

V2623 (IC)	V2625 (IC)	V2627 (IC)	V2629 (PA)(IC)
V2624 (IC)	V2626 (IC)	V2628 (IC)	

611 Modifiers

The following service code modifiers are allowed for billing under MassHealth.

26	Professional Component
TC	Technical Component

The following modifiers are for Provider Preventable Conditions (PPCs) that are National Coverage Determinations.

PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

For more information on the use of these modifiers, see Appendix V of the provider manual.