

Chapter 20

Eyeglass and Vision Care Services

Vision care providers enrolled with IMCare are not required to work with any specific State-contracted laboratory in order to serve IMCare members. Vision care providers must bill IMCare directly, using standard billing forms and Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes. Providers must bill IMCare their usual and customary (U&C) charge for their services. IMCare will pay the amount billed or the maximum allowable, whichever is lower.

Definitions

Comprehensive Vision Examination: A complete evaluation of the visual system. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields, basic sensorimotor examination, biomicroscopy, examination with cycloplegia or mydriasis, and tonometry.

Date of Service (DOS): The actual date the service is performed or the supplies are dispensed. The DOS for frames and lenses is the date the eyeglasses were ordered. The DOS for the dispensing fee is the date the eyeglasses are delivered to the member.

Deluxe Eyeglass Frame: An eyeglass frame with features that make it more durable than a standard frame, such as spring hinges or memory metal construction.

Dispensing Services: The technical services (fitting of spectacles) necessary for the design, fitting, and maintenance of glasses (frames and lenses) as prescribed by an optometrist or ophthalmologist.

Eyeglass/Vision Service: A comprehensive or intermediate vision exam provided by an optometrist or ophthalmologist and/or eyeglasses dispensed by an optician, optometrist, or ophthalmologist.

Eyeglasses/Spectacles: A pair of lenses mounted in a frame to aid vision, as prescribed by an optometrist or ophthalmologist.

Intermediate Vision Examination: An evaluation of a new or existing specific visual problem complicated with a new diagnosis or management problem not necessarily relating to the primary diagnosis.

Ophthalmologist: A physician who has academic training in ophthalmology beyond the state requirements for licensure and experience in the treatment and diagnosis of the diseases of the eye.

Optician: A supplier of eyeglasses to a patient as prescribed by the patient's optometrist or ophthalmologist.

Optometrist: A person licensed as an optometrist under Minnesota law.

Eligible Providers

Ophthalmologists, opticians, and optometrists are allowed to enroll with IMCare and provide and bill for services within their scope of practice.

Eligible Members

Eyeglasses and vision care services are covered for eligible IMCare members who require vision correction.

IMCare members are eligible to receive a new pair of glasses every 24 months or more frequently if they meet the medical necessity criteria identified below.

IMCare members are able to obtain a second pair of eyeglasses within the two-year dispensing period without a Service Authorization as long as the “Medical Necessity Replacement Criteria for Receiving Eyeglasses More Frequently than Every Two Years” are met. Providers should only dispense a second pair of eyeglasses if these criteria are met. In addition, providers are responsible for documenting the reason the second pair of eyeglasses was provided and for maintaining that documentation in the member’s medical record.

IMCare reserves the right to deny coverage for a second pair of eyeglasses if, upon review of the medical record, there is no documentation that the replacement criteria were met.

A Service Authorization (*Itasca Medical Care (IMCare) Authorization Request*) is still required for all members, including IMCare Classic (HMO SNP), before providing a member with more than two pairs of eyeglasses in a two-year dispensing period.

Vision care providers must verify eligibility for replacement glasses by calling the IMCare at **1-800-843-9536** (toll free) to determine when the member’s last pair of IMCare eyeglasses was dispensed.

Covered Services

Documentation of medical necessity must be kept in members’ medical records. The following services are covered services when medically necessary and coverage criteria are met:

1. Comprehensive vision examinations
2. Intermediate vision examinations
3. One dispensing fee within a 30-day period
4. Eyeglass frames
5. Deluxe eyeglass frames for children or for adults with cognitive disabilities or seizure conditions (a specific diagnosis is required for deluxe frames for members age 21 or over)
6. Glass, plastic, or polycarbonate lenses for children or adults (IMCare does not require children to have polycarbonate lenses)
7. Tinted or photochromatic (transition) lenses for certain childhood illnesses or visual or seizure conditions when clear glass/plastic lenses may pose a safety risk (a specific diagnosis is required).
8. Service Authorization (*Itasca Medical Care (IMCare) Authorization Request*) is required before providing polarized lenses.
9. Ultraviolet (UV) lenses for certain childhood, visual, or seizure conditions when standard lenses may pose a risk (a specific diagnosis is required)
10. High-index lenses when the correction in either eye is plus or minus 6.00 diopters or greater
11. Aspherical hand-held magnifiers (3.7 X 11.0 diopter), when medically necessary
12. Double segs (FT25, FT28), plastic or glass, when medically necessary
13. Fresnel prism or slab off prism, when medically necessary
14. Repairs to frames and lenses purchased through IMCare
15. UV coating

Contact Lenses

Contact lenses are covered without authorization if prescribed for aphakia, keratoconus, aniseikonia, or bandage lenses. All other diagnoses/conditions are not covered.

Claims for contact lenses for the same DOS will be denied. When performed bilaterally, bill two units on one line with modifier 50. An appropriate diagnosis must be included.

Bandage/Therapeutic Lenses: 92071 and 92072. Includes the supply of the contact lenses. Claims for contact lenses for the same DOS will be denied. When performed bilaterally, bill two units on one line with modifier 50. Must include an appropriate diagnosis.

Bilateral prescribing/fitting of contact lenses except for aphakia: 92310 and 92314. Use modifier 52 when prescribing and fitting one eye.

Contact lenses: S0500, V2500 – V2599. One unit = one contact lens. Planned replacement contact lenses may be dispensed as multi-packs when prescribed for these conditions: aphakia, keratoconus, or aniseikonia or bandage lenses. The following additional dispensing limits apply:

Contact Lenses		
Procedure Code	Brief Definition	Limitations
V2500 - V2513 V2530 -V2599	Polymethylmethacrylate (PMMA), gas permeable, gas impermeable contact lens, and For : Aphakia (H27.00-H27.03), Aniseikonia(H52.32), Keratoconus (H18.601-H18.629)	2 units (1 per eye) per dispensing
V2520– V2523	Hydrophilic contact lens For: Aphakia (379.31, 743.35), Aniseikonia(367. 32), Keratoconus (371.60,371.61,371.62	1 multi-pack per eye, up to 12 units per dispensing
92071, 92072	Bandage Lenses (92071, 92072, S0515)	

Eyeglasses

1. Lenses covered by IMCare must be first quality impact resistant glass, plastic or polycarbonate single vision, bifocal, or trifocal lenses.
2. Lenses must conform to the American National Standards Institute (ANSI) “Recommendation for Prescription Ophthalmic Lenses,” ANSI’s most current standards, and the United States Food and Drug Administration (FDA) requirements for impact resistance.
3. All lenses must be finished (hardened and edged) and assembled in the frame.
4. A new eyeglass case must be included with each pair of eyeglasses.
5. Eyeglasses found by the member to be unsatisfactory due to defective workmanship and/or materials must be replaced or repaired by the provider without cost to the member or IMCare.
6. Errors made in prescribing or dispensing are the responsibility of the prescribing and/or dispensing provider and are not to be billed to IMCare or the member.

Eyeglass Frames

All eligible IMCare members may select any approved standard frame. Members under age 21 and adult members with cognitive disabilities or seizure disorders may select approved deluxe frames. When a deluxe frame is ordered for a member age 21 or over, the provider must include an appropriate diagnosis code on the claim.

Members may select approved frames without lenses when purchasing non-covered lenses. The provider must be able to mount the non-covered lenses in the frames. The provider must clearly inform the member that the frames will be covered; however, all costs associated with the non-covered lenses and mounting of the lenses will be the member's responsibility.

If a member chooses to purchase **upgraded frames** (such as a more fashionable frame), the member is responsible for the entire cost of the frames. The member cannot pay for the difference of the upgrade. The provider can only bill IMCare for the covered lenses.

IMCare will not pay for the dispensing fee, repairs, or adjustments made to upgraded products or non-covered items.

Bill services provided to IMCare members using the 837P format for all services.

Eyeglass Lenses

Members with medical conditions that may be affected or aggravated by bright or changing light conditions may require tinted, UV, polarized, or photochromatic lenses. When photochromatic (transition) or, tinted lenses are ordered, the provider must include an appropriate diagnosis on the claim. A Service Authorization is required before providing polarized lenses. ~~When UV lenses are ordered and provided, the provider must include an appropriate diagnosis on the claim.~~

Members may request covered lenses for member-owned frames. If a member chooses to purchase upgraded lenses that are not medically necessary (such as high-index plastic, transition lenses, no-line bifocals), the member would be responsible for the entire cost of the lenses. The member cannot pay for the difference of the upgrade. The provider may only bill for the covered frames.

IMCare will not pay for the dispensing fee, repairs, or adjustments made to upgraded products or non-covered items.

Bill services provided to IMCare members using the 837P format for all services.

Medical Necessity Criteria for Receiving Eyeglasses More Frequently than Every Two Years

It is expected that with reasonable care, eyeglasses should not need to be replaced due to loss or damage more than once in a two-year dispensing period. However, vision providers may dispense new eyeglasses, even though two years have not passed since the member's last pair was dispensed. IMCare members are able to obtain a second pair of eyeglasses within the two-year dispensing period without a Service Authorization as long as the one or more of following criteria is met:

1. There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye
2. There is a shift in axis of greater than 10 degrees in either eye
3. A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically

necessary

4. There is a change in the member's head size that warrants a new pair of eyeglasses
5. The member has had an allergic reaction to the previous pair of eyeglasses
6. The original pair is lost, broken, or irreparably damaged. If the original pair is lost, broken, or damaged beyond repair, the eyeglasses will be replaced with an identical pair of eyeglasses, unless the identical frame is not available. The original pair must also be the first pair of eyeglasses provided in a dispensing period.
7. The member is a child (up to 21 years of age).

IMCare reserves the right to deny coverage for a second pair for eyeglasses if, upon review of the medical record, there is no documentation that the replacement criteria were met.

A Service Authorization (*Itasca Medical Care (IMCare) Authorization Request*) is required for all members, including IMCare Classic members, before providing a member with more than two pairs of eyeglasses in a two-year dispensing period. If the eyeglasses are lost, broken, or damaged beyond repair, the eyeglasses will be replaced with an identical pair of eyeglasses, unless the identical frame is not available (in which case a different frame will be substituted). **The dispensing provider must obtain a written statement from the member (or the member's caretaker) explaining why the eyeglasses were broken, lost, or can't be repaired, and must send a copy of this documentation to IMCare with the Service Authorization request.**

Non-Covered Services

1. Replacement of lenses or frames to change the style or color
2. Cosmetic services
3. Tints or polarized lenses for fashion purposes
4. Protective coating for plastic lenses
5. Edge and anti-reflective coating of lenses
6. Industrial, sport eyeglasses, or glasses for computer screen usage, unless they are the member's only pair and are necessary for vision correction
7. Invisible bifocals or progressive bifocals
8. Contact lenses requiring authorization that was not obtained
9. Replacement of lenses or frames due to provider error in prescribing, frame selection, or measurement
10. Eyeglasses found by the member to be unsatisfactory due to defective workmanship/materials must be replaced or repaired by the provider without cost to the member or to IMCare
11. High-index plastic lenses
12. Eyeglasses or lenses for occupational or educational needs, unless it is the member's only pair and it is necessary for vision correction
13. Services or materials that are considered experimental or not clinically proven by prevailing community standards or customary practice
14. Backup eyeglasses or split prescription into two pairs of eyeglasses
15. Reading glasses without a prescription
16. Saline or other solutions for the care of contact lenses
17. Vision therapy for learning disabilities, including dyslexia

Repairs/Replacement

Billing for Repairs/Replacement

Repairs made to frames and lenses not under warranty may be billed to IMCare. Only frames and lenses purchased through IMCare are covered for repairs.

1. Bill replacement frame or lenses using the appropriate frame or lens code with modifier RA. Do not bill a

dispensing code for replacement of just the frame or lenses.

2. A dispensing fee may only be billed if you are replacing a complete set of glasses (lenses and frame). Bill repairs to frames using either code 92370, repair and refitting of spectacles, or 92371, repair of spectacle prosthesis for aphakia. These codes will not require any additional modifiers. Do not bill a dispensing code for repairs.
3. Bill dispensing fees only for complete set of frame and lenses, and only once within a 30-day period.

Please note: The RP modifier is invalid.

Members with Private Health Insurance Coverage

Members with private insurance coverage who have an eyeglass benefit must obtain their eyeglasses, eye examination, and vision services through their primary insurance. Members whose private insurance plan does not cover eyeglasses as a benefit must receive eyeglasses from an enrolled IMCare optical provider.

Service Authorization

Authorization request forms can be found on the IMCare website (www.imcare.org). Complete the appropriate form and include all codes for the eyewear, including the dispensing fee and billed amount for each code. The complete form should also include an explanation of the medical necessity of additional eyeglasses.

Follow the instructions on the form or mail your authorization request to:

IMCare
1219 Southeast 2nd Avenue
Grand Rapids, MN 55744

Documentation

Document the following situations in the member's medical record:

1. A change in the member's head size that requires eyeglasses before 24 months
2. Changes in the member's vision that meet the medical necessity criteria above and that require eyeglasses before 24 months
3. If the member's eyeglasses have been lost, stolen, or irreparably damaged and therefore require replacement with an identical pair before 24 months
4. If eyeglasses are dispensed for occupational, educational, industrial, or sports needs but these eyeglasses are the member's only pair and they are needed for vision correction

Billing

1. Bill all claims for vision care items and services to IMCare using the appropriate claim format.
 - a. Independent clinics/facilities providing vision services: bill claims for covered services to IMCare using the 837P claim format.
 - b. Provider based clinics providing vision care services: bill eyewear on the 837I claim format and bill professional services on the 837P claim format.
2. Each line item submitted charge must reflect the provider's U&C charge.
3. Bill frames, lenses, dispensing fee, repairs, and other covered items and services using HCPCS (Level I and II) codes and guidelines.
 - a. Fitting codes 92340 – 92342 should only be included on the claim when billing for a **complete** set of glasses (frame and two lenses).

- b. Claims for lenses only or replacement of frames (V2020 or V2025 with the RA modifier) **cannot** be billed with a fitting code.
 - c. Bill repairs to frames using either code 92370, repair and refitting of spectacles, or 92371, repair of spectacle prosthesis for aphakia. These codes will not require any additional modifiers. Do not bill a dispensing code for repairs.
4. When billing for two of the same lens codes, either bill one service line with two units and no modifier or two lines with the appropriate RT and LT modifiers.
 5. Include the appropriate *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* diagnosis code on the claim. Examples of situations that should be noted in the diagnosis include the following:
 - a. A medical condition that requires either tinted or photochromatic lenses
 - b. Aphakia, keratoconus, or aniseikonia that requires contact lenses
 - c. Allergic reaction to previous frame that requires new frames
 - d. Medical condition that requires an aspherical hand-held magnifier (3.7 X 11.0 diopter)
 - e. Medical condition that requires Fresnel prism, slab off prism

Copays

Eyeglasses (complete frames and lenses) may be subject to a copay. A copay does not apply to eyeglass repairs or if only the frames are dispensed or only the lenses are dispensed. Review the member's benefits to determine whether the member is subject to a copay.

Billing the Member

The member may purchase non-covered add-ons and non-covered items. Add-ons are lens treatments that can be added to a pair of covered lenses and frames. Examples are: lens coating, special edge treatments, scratch resistant coating, anti-reflective lens coating, etc. Members may pay for the cost only of the add-on products. The provider must inform the member before providing the item that it is not covered by IMCare and that the member is responsible for the payment of the add-on item.

Members may be billed for non-covered items. If a member chooses to purchase **upgraded lenses** that are not medically necessary (such as high-index plastic, transition lenses, no-line bifocals) or an **upgraded frame** that is not medically necessary (such as a more fashionable frame), the member is responsible for payment of the entire cost. The provider cannot bill the member for the difference between covered lenses or frame and the upgraded lenses or frame. IMCare will not pay for the dispensing fee, repairs or adjustments made to upgraded products or non-covered items.

Maximum Allowable Rates

Providers must bill IMCare at their U&C charge. IMCare will pay the lower of the submitted charge or the maximum allowable rate.

Vision Therapy/Orthoptics and Pleoptics

Vision Therapy/Orthoptics and Pleoptics		
Procedure Code	Brief Definition	Authorization Requirements

92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	Service authorization is required
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Visual Therapy/Orthoptics/Pleoptics Coverage Criteria

This service must be provided only when the following criteria are met. If, during an audit, the medical record does not have indication of these criteria, any payment made towards orthoptic and/or pleoptic training may be recovered by IMCare due to not meeting medical criteria.

1. Diagnosis and treatment of amblyopia, sensory or motor strabismus, and accommodative disorders causing subjective visual complaints that are not relieved by wearing prescription eyewear
2. Home visual therapy is to be used, including home treatment with patching, lens fogging, red/green/polaroid filters, and other lenses/devices
3. Visual therapy for amblyopia is limited to children under age 10. If improvement is not noted after four sessions, the member must be referred to an appropriate professional (e.g., neurologist or ophthalmologist) for further evaluation.

Billing for Ocular Photodynamic Therapy (CPT code 67221) is covered only for ICD-10-CM H35.32 (exudative age-related macular degeneration). No separate payment for the intravenous infusion service is allowed. Payment for the infusion is packaged into CPT code 67221.

Payment Limitations

The physician monitoring progress may bill for a limited examination in addition to the orthoptic/pleoptic training. Documentation in the medical record that the physician has seen the member and performed the necessary procedures for a limited examination is required. Examinations to evaluate visual therapy are limited to one per week.

Legal References

[MN Stat. sec. 256B.04, subd. 14](#) – Duties of State Agency: Competitive bidding

[MN Stat. sec. 256B.0625, subd. 12](#) – Covered Services: Eyeglasses, dentures, and prosthetic devices

[MN Rules part 9505.0277](#) – Eyeglass Services

[MN Rules part 9505.0445](#) – Payment Rates

[Title 42 Code of Federal Regulations \(CFR\) Part 410](#) – Supplementary Medical Insurance (SMI) Benefits

[42 CFR 411](#) – Exclusions from Medicare and Limitations on Medicare Payment

[42 CFR 440.120\(d\)](#) – Prescribed drugs, dentures, prosthetic devices, and eyeglasses