Billing, Coding and ICD-10 for Medically Indicated Contact Lenses

PRESENTED BY
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GAS PERM LENS INSTITUTE
2016
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  - FDA “Off-Label” Uses will not be discussed
The objective of this course is to discuss methods for coding and billing for medically necessary contact lenses and for incorporating ICD-10-CM into medically necessary contact lens prescribing.
Learning Objectives

- Attendees of this course will learn:
  - Effective Coding and Billing strategies for Medically Necessary Contact Lenses (MNCL)
  - How ICD-10-CM has changed the game for MNCL
This meeting is a gathering of competitors, which is one of the two criteria for violating the Sherman Anti-Trust Act. The other criterion for a *per se* violation is to agree to, or appear to agree to, do something, like set fees, or boycott a supplier, or another competitor. This lecture includes a discussion of fees. HOWEVER, THIS LECTURE IS NOT INTENDED IN ANY WAY TO BE CONSTRUED AS A DISCUSSION OF FEE SETTING. THE EXAMPLES GIVEN ARE INSTRUCTIONAL, AND ARE NOT INTENDED IN ANY WAY TO ENCOURAGE ANYONE TO SET ANY FEE AT ANY AMOUNT. QUESTIONS ABOUT FEES WILL NOT BE ANSWERED, AND DISCUSSION ABOUT FEES AMONG THE ATTENDEES OF THIS LECTURE, DURING THIS LECTURE, WILL NOT BE PERMITTED, AND IS STRONGLY DISCOURAGED AT ANY TIME AFTER THIS LECTURE!
A Story About Joseph Lister
I believe that it is a moral failure to possess a skill or a body of knowledge that can end human suffering, and then fail to use that skill or knowledge because you do not charge enough to make that service a viable part of your practice.

Most doctors fail in medically necessary prescribing not because they lack the skill, but because they lose interest and motivation when they start to lose money.

When you charge enough so that you don’t lose money, then you stay motivated enough to solve these complicated cases. I submit to you, that that is ethical!
“Clarke, Everything That Happens in Your Practice Is Your Fault”

- IRV BORISH
What We Say Doesn’t Matter (Sorta)

There is no escaping the fact that YOU have to do your homework to be successful at billing for medical services. There are enough contractual differences between carriers and between regions, that you have to determine what the payment policies and fees are for each type of service and for each carrier. If you practice in more than one locale, you have to do this legwork for each locale—PERIOD!
Introduction

- Basic Third Party Concepts
  - What is the Consumer / Provider / Payor / Purchaser Relationship?
  - What is the Definition of “Medically Necessary?”
  - What Is the Diagnosis / Service / Payment Relationship?
  - What Are “Covered” and Non-Covered” Services?
- Optometric Financial Oath
- Medically Necessary Billing and Coding
- Specialty Billing and Coding
Before You Can Do This...
You Have To Go Through This...
I am Vehemently Against This Practice... When It Comes to Elephants. 😊
What Is a “Third Party” Payor Relationship?

First and foremost—it is a contract relationship!!!
What Is a “Third Party” Payer Relationship?

- Private Carriers
  - Definitions
  - Limits
    - Reimbursement Fee Schedules
    - Eligibility Periods
  - Exclusions
  - Pre-Existing Conditions
  - Plan Limits

- Carrier Determination Policies
- Contractual Obligations
  - Filing Requirements
  - Balance Billing Policies
  - Inclusions Policies
- Civil Remedies
What Is a “Third Party” Payer Relationship?

- Government Contracts
  - Medicare
    - National Carrier Determination Policies (NCD)
    - Local Carrier Determination Policies (LCD)
  - Medicaid
    - State Coverage Policies
  - Criminal Remedies
The Third Party Dance

- Consumers of Health Care Services
  - Patients

- Providers of Health Care Services
  - Physicians (Check that Definition! Sometimes OD’s Are Physicians)
  - Non-Physician Providers
    - OD’s, Sometimes
    - Nurses
    - Chiropractors
    - Psychologists
The Third Party Dance

- Purchaser of Health Care Services
  - Governments
  - Employers
  - Individuals
- Payors of Health Care Services
  - Administrative Entities that Meet Certain Criteria to Be “Qualified Health Plans” that Insure Contract Compliance and Fund Transfers Between Purchasers and Payors
The Third Party Dance

Payors of Health Care Services

- Federal Government
  - Medicare
    - Medicare Administrative Contractor (A/B MAC) and Jurisdictional Areas
    - Durable Medical Equipment Medicare Administrative Carriers (DME MAC)
  - Medicaid / CHIPS
  - Veteran’s Administration and Tri-Care
  - National Health Services Corp / Indian Health Services
  - Railroad
- State Governments
  - Medicaid
  - CHIPS
The Third Party Dance

- Payors of Health Care Services
  - Private Payors
    - Indemnity Carriers
      - Indemnity
      - HMO
      - PPO
    - ERISA Self-Insured
  - Local Governments
    - County Indigent Care Services
Health Care Services

- Contracted Services
  - Negotiated Coverage Products Between Purchasers and Payors
  - Most Indemnity Carriers Have Several Standard Plan Offerings From Which Purchasers May Choose
  - Some Have Custom Negotiated Plans

- Health Care Services
  - Covered Service—Deemed Medically Necessary in the Terms of the Negotiated Coverage Product
  - Non-Covered Services—Deemed Not Medically Necessary in the Terms of the Negotiated Coverage Product
Covered vs. Non-Covered

- This Concept Is Important to Medically Necessary Contact Lens Prescribing
- Non-Covered Services Are Listed By Exclusions in the Negotiated Coverage Product (“Insurance Plan”) As Detailed in the “Summary Plan Description” (SPD)
- Non-Covered Service Exclusions Do Not Decide What Care You Provide, Just Who Pays for the Care You Provide
  - Independent Clinical Judgment
  - Non-Covered Services Are Paid by the Consumer Directly to the Provider
I, [state your name], do solemnly swear or affirm that neither I, nor any of my business partners, spouses, concubines, long time companions, assigns, or heirs will never, ever, never, ever, never sign, or caused to be signed, any contract that I have not fully read and do not fully understand. Further, I swear or affirm that I shall not take food out of the mouths of my beloved family members by entering into any contract that is so onerously structured as to make no financial sense for me or my business. This oath I pledge, before God, Irv Borish, and all other Deities, to be my solemn vow.
Proper Storage Facility for Most Contracts
What Is the Definition of Medically Necessary?

AMA Definition (1999)

“Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating, or rehabilitating an illness, injury, disease or its associated symptoms, impairments, or functional limitations in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physician or other health care provider.”
The CMS Definition

As published in CMS IOM Pub. 100-08, Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

Safe and effective.

Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).

• Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  • Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  • Furnished in a setting appropriate to the patient's medical needs and condition.
  • Ordered and furnished by qualified personnel.
  • One that meets, but does not exceed, the patient's medical needs.
  • At least as beneficial as an existing and available medically appropriate alternative.
What Does That Mean?

- The Patient Must Have an Illness, Injury, or Disease That Has a Symptom, Impairment, or Functional Limitation
- A Test Performed Must Have an Indication (See the Previous Point), and the Result Must Influence the Treatment Plan
- A Treatment Must Be a Standard of Care
- A Treatment Cannot Be for Mere Convenience (Cosmetic Lenses)
Establishing Medical Necessity for a Covered Service

- A Chief Complaint Rational to a Covered Service Such As an Injury, Illness, or Disease
- Providing a Covered Service Must Be Indicated by the Chief Complaint and Must Be Ordered
- If the Covered Service Is a Diagnostic Test, then the Diagnostic Test Must Be Interpreted and It Must Affect Your Clinical Decision Making
More on Documentation for Medical Necessity
## More on Documentation for Medical Necessity

### 92025 Corneal Topography Ordered and Reviewed by Clarke D Newman, OD, FAAO: [Signature]

**Indication:**
- [ ] Diagnose a Decrease in Vision thought to be Due to a Corneal Disease, Degeneration, Deformity, or Injury
- [ ] Monitor a Previously Diagnosed Corneal Disease, Degeneration, Deformity, or Injury
- [ ] Pre-Operative Evaluation of the Cornea to Rule Out Corneal Disease, Degeneration, Deformity, or Injury as a Contraindication to Surgery
- **[x]** Post-Operative Evaluation of the Cornea to Rule Out Corneal Disease, Degeneration, Deformity, or Injury Resulting From the Surgery

**Interpretation:**
- [ ] No Detectable Defect
- [ ] [267.21] Regular Astigmatism
- [ ] [267.22] Irregular Astigmatism
- [ ] [366.10] Subjective Visual Disturbance, Unspecified
- [ ] [366.15] Other Visual Distortions
- [ ] [371.63] Central Opacity of Cornea
- [ ] [376.31] Phlyctenum Keratoconjunctivitis
- [ ] [371.31] Folds and Rupture of Bowman’s Membrane
- [ ] [371.46] Nodular Degeneration of Cornea (Ectasian’s)
- [ ] [371.48] Peripheral Degenerations of Cornea (Turlier’s)
- [ ] [371.57] Endothelial Corneal Dystrophy (Fuchs’)

**Plan:**
- [ ] Monitor
- **[x]** Prescribe Medically Necessary Contact Lenses
- [ ] Refer for Surgical Consultation
- [ ] Initiate Medical Therapy

### Notes:
- [ ] [371.61] Keratoconus, Stable Condition
- [ ] [371.62] Keratoconus, Acute Hydrops
- [ ] [371.78] Corneal Deformity, Unspecified
- [ ] [371.79] Keratoconus
- [ ] [371.10] Pellucid Marginal Degeneration
- [ ] [371.43] Bank-Shaped Keratopathy
- [ ] [371.45] Nodular Corneal Degeneration
- [ ] [372.41] Peripheral Pterygium, Stationary
- [ ] [372.43] Peripheral Pterygium, Progressive
- [ ] [43.41] Anomalies of Corneal Size and Shape
Guidance Materials

- **Websites**
  - Fiscal Intermediary
    - Find Your Jurisdiction
  - Private Carriers
- **Reference Books**
  - 2012 ICD-9-CM
  - 2014 CPT
  - 2014 HCPCS
  - 2015 ICD-10-CM
- **Meetings & Journals**
Reference Books
Seriously? It is 2016. Unbelievable!
Reference Books
Web Based Guidance
Establishing the Diagnostic Code Set

- **Diagnosis Codes**
  - ICD-10-CM, Used since October 1, 2015—BIG change

- **Procedure Codes**
  - CPT Level I Codes (Created by the AMA CPT Editorial Panel)
  - HCPCS (CPT Level II)

- **Carrier Determination Policies**
  - National Carrier Determinations (NCD) For Eyes NCD 80
  - Local Carrier Determinations (LCD)
What We Say Doesn’t Matter (Sorta)

There is no escaping the fact that YOU have to do your homework to be successful at billing for medical services. There are enough contractual differences between carriers and between regions, that you have to determine what the payment policies and fees are for each type of service and for each carrier. If you practice in more than one locale, you have to do this legwork for each locale—PERIOD!
Very Important Concept:
A Tautology

It Is Not What You Get Paid!!!!

It Is What You Get to Keep at Audit!!!!
Understanding CPT Codes

- Code Text
  - Plain Language Rules, Unless Specifically Superseded by Other Instructions
- Code Sub-Text
  - Often, These Other Instructions Are Contained in Sub-Text Comments
- Code Pre-Text / Preamble
  - A Preamble Can Contain Information That Shapes a Code or a Group of Codes
    - E/M Codes Have a Preamble and Code Subtexts
    - 9231x Codes Have a Preamble
- CPT Assistant
- CPT Changes
- CMS Pub-100 Guidance
  - NCD’s Are Promulgated Here
Evaluation and Management Services—New Patient

- 99201—Level One
- 99202—Level Two
- 99203—Level Three
- 99204—Level Four
- 99205—Level Five

A “New Patient” is a patient who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the previous three years.
Evaluation and Management Services—Established Patient

- 99211—Level One
- 99212—Level Two
- 99213—Level Three
- 99214—Level Four
- 99215—Level Five
General Ophthalmological Services

- **New Patient**
  - 92002—Intermediate Service
  - 92004—Comprehensive Service

- **Established Patient**
  - 92012—Intermediate Service
  - 92014—Comprehensive Service
E/M vs. General Ophthalmological Services

- We Have Reached a Point in Code Requirements and Reimbursement That One Should Use the E/M Codes for All Medically Necessary Patients, Whenever Possible.
Office or Other Outpatient Consultations

- 99241—Level One
- 99242—Level Two
- 99243—Level Three
- 99244—Level Four
- 99245—Level Five

New or Established

- Only Appropriate When Requested by a Physician (That Would Be US, or an MD, DO, DC, DDS, DPM) or Other Appropriate Source (PA, RN, NP, DC, PT, OT, SW, Psych, Attorney, or Ins. Company)

- The Request May Be Written or Verbal That Is Documented in the Patient Record, and a Written Report Is Required in Return

- CMS Publication 100-4, Chapter 12, Section 30.6.10

- New CPT Preamble to the E/M Codes that speaks to the “Transfer of Care” vs. “Concurrent Care”
Office or Other Outpatient Consultations

- 99241—Level One
- 99242—Level Two
- 99243—Level Three
- 99244—Level Four
- 99245—Level Five
- New or Established

Only Appropriate When Requested by a Physician (That Would Be US) or Other Appropriate Source (PA, RN, NP, DC, PT, COT, SW, Psych, Attorney, or Ins. Company)

The Request May Be Written or Verbal That Is Documented in the Patient Record, and a Written Report Is Required in Return

CMS Change Request 6740

CMS Publication 100-4, Chapter 12, Section 30.6.1
Office or Other Outpatient Consultations

- These Codes Used to Be the Bread and Butter of Specialty Lens Prescribing When Running a Consultation Practice
- Subsequent (Follow Up) Visits Are Billed as Either E/M Services or General Ophthalmological Codes
- All but Dried Up
Service Code Components

- **Global Component**
  - All Components Necessary to Perform the Procedure

- **Technical Component**
  - The Portion of the Global Fee Attributed to Performing the Procedure
  - Designated By Modifier -TC

- **Professional Component**
  - The Portion of the Global Fee Attributed to the Interpretation of the Procedure Results
  - Designated By Modifier -26

- Not All Procedure Codes Are Split Into Technical and Professional Components; the CMS Fee Schedule Will Break It Out for You
Multiple Procedure Payment Reduction (MPPR)

- New in January 2013

For ophthalmology services, full payment is made for the -TC service with the highest payment under the MPFS. Payment is made at 75 percent for subsequent -TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group NPI) to the same patient on the same day.

What Codes Are Affected?

- 76510
- 76511
- 76512
- 76513
- 76514
- 76516
- 76519
- 92025
- 92060
- 92081
- 92082
- 92083
- 92132
- 92133
- 92134
- 92136
- 92228
- 92235
- 92240
- 92250
- 92265
- 92270
- 92275
- 92283
- 92284
- 92285
- 92286
The Resourced Based Relative Value System (RBRVS)

- This System Was Designed to Assign Values to Services Based on the “Realities” of Delivering that Service.
- These Values Are Established and Modified by The AMA Relative Value Unit Audit Committee (RUC), and Are Supposed to Represent the “Average Work” to Deliver the Service in Question.
- $\text{RVU} = \text{Physician Work} + \text{Practice Expense} + \text{Malpractice Expense} \times \text{GPCI}$
- Payment Is Determine by Multiplying the RVU by a “Conversion Factor” that Is Determined by the Respective Payors—Mainly CMS.
- The New Merit-Based Incentive Payment System (MIPS) Replaces the Old Sustainable Growth Rate Formula (SGR).
- As of January 21, 2016, CMS’ Conversion Factor $35.8279$
-22: **Unusual Procedural Services** “When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier -22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).

- This Modifier Should Not be Appended to E/M Services
- Example: Using the 92310 on a Bi-Toric or Quadrant Specific Prescription
- Example: Difficult Refraction
-22: Unusual Procedural Services “When the Work Required to Provide a service is substantially greater than typically required, it may be identified by adding modifier -22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).

This Modifier Should Not be Appended to E/M Services

Example: Using the 92310 on a Bi-Toric or Quadrant Specific Prescription

Example: Difficult Refraction

In January 2013, CMS decided that the -22 modifier only applied to surgeries or 60000 codes. HOWEVER, CPT rules state that the plain language text of a discrete code is operative, and the code does not say “surgical service,” it says “service”
“Modifier -22 is for physician reporting only (facilities may not report modifier -22), and should not be appended to evaluation and management (E/M) codes, according to CPT® guidelines. Most commonly, modifier -22 will accompany surgical claims—although modifier -22 also might apply to anesthesia services, pathology and lab services, radiology services, and medicine services.”

-AAPC, 2014
-52: **Reduced Services** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified.

- Example: 92310 is a Bilateral Procedure. If you prescribe for one eye, you should use the reduced service modifier.

- Example: 92025 is a Unilateral or Bilateral Procedure. If you perform the test on both eyes or just one eye only, you do not use the -51 modifier.

- Example: 92285 specifies neither Bilateral or Unilateral. Controversially, one does not need to use the -51 modifier on these codes even though the code is specified as “Bilateral”
"I'll want to run a few tests on you, just to cover my ass."
Other Important Procedure Codes

- **92015**—Determination of Refraction State
  - Basic
  - Complex (Use the -22 Modifier for 150% of the U&C Fee)

- **92025**—Computerized Corneal Topography, Unilateral or Bilateral, With Interpretation and Report

- **92312**—Scanning Computerized Ophthalmic Diagnostic Imaging, Anterior Segment, With Interpretation and Report, Unilateral or Bilateral

- **92225**—Ophthalmoscopy, Extended With Retinal Drawing, (e.g., For Retinal Detachment, Melanoma), With Interpretation and Report; Initial (Unilateral)
Other Procedure Codes

- 92285—External Ocular Photography With Interpretation and Report for Documentation of Medical Progress (e.g., Close-Up Photography, Slit Lamp Photography, Goniophotography, Stereo-Photography (Bilateral)
- 92286—Anterior Segment Imaging With Interpretation and Report; With Specular Microscopy and Endothelial Cell Count (Bilateral)
- 76514—Corneal Pachymetry, Unilateral or Bilateral (Determination of Corneal Thickness)
- 92499—Abberometry (Unlisted ophthalmological service or procedure)
ICD-10-CM

All of the diagnostic codes that could conceivably be used for medically necessary contact lens prescribing...I think...maybe...I could be wrong...anyway, it is a lot of codes.
<table>
<thead>
<tr>
<th>Code Descriptor</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progressive high (degenerative) myopia</td>
<td>H44.23</td>
</tr>
<tr>
<td>Hypermetropia</td>
<td>H52.03</td>
</tr>
<tr>
<td>Myopia</td>
<td>H52.13</td>
</tr>
<tr>
<td>Astigmatism, regular</td>
<td>H52.229</td>
</tr>
<tr>
<td>Astigmatism, irregular</td>
<td>H52.219</td>
</tr>
<tr>
<td>Anisometropia</td>
<td>H52.31</td>
</tr>
<tr>
<td>Aniseikonia</td>
<td>H52.32</td>
</tr>
<tr>
<td>Presbyopia</td>
<td>H52.4</td>
</tr>
<tr>
<td>Protan defect</td>
<td>H53.54</td>
</tr>
<tr>
<td>Deutan defect</td>
<td>H54.53</td>
</tr>
<tr>
<td>Tritan defect</td>
<td>H54.55</td>
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</table>
ICD-10-CM Codes for Medically Necessary Contact Lens Prescribing

<table>
<thead>
<tr>
<th>Code Descriptor</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Nystagmus</td>
<td>H55.00—H55.09</td>
</tr>
<tr>
<td>Code Descriptor</td>
<td>ICD-10 Code</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Absence of iris (Aniridia)</td>
<td>Q13.1</td>
</tr>
<tr>
<td>Achromatopsia</td>
<td>H53.51</td>
</tr>
<tr>
<td>Adherent leukemia</td>
<td>H17.00—H17.03</td>
</tr>
<tr>
<td>Albinism</td>
<td>E70.20—E70.9</td>
</tr>
<tr>
<td>Anterior corneal pigmentation</td>
<td>H18.011—H18.019</td>
</tr>
<tr>
<td>Aphakia</td>
<td>H27.00—H27.03</td>
</tr>
<tr>
<td>Arcus senilis</td>
<td>H18.411—H18.419</td>
</tr>
<tr>
<td>Argentous corneal deposits</td>
<td>H18.021—H18.029</td>
</tr>
<tr>
<td>Atrophy of the globe</td>
<td>H44.52</td>
</tr>
<tr>
<td>Band keratopathy</td>
<td>H18.421—H18.429</td>
</tr>
<tr>
<td>Bullous keratopathy</td>
<td>H18.10—H18.13</td>
</tr>
</tbody>
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<th>Code Descriptor</th>
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<tbody>
<tr>
<td>Central corneal opacity</td>
<td>H17.10—H17.13</td>
</tr>
<tr>
<td>Coloboma of iris</td>
<td>Q13.0</td>
</tr>
<tr>
<td>Congenital aphakia</td>
<td>Q12.3</td>
</tr>
<tr>
<td>Congenital corneal opacity</td>
<td>Q13.3</td>
</tr>
<tr>
<td>Corneal ectasia</td>
<td>H18.711—H18.719</td>
</tr>
<tr>
<td>Corneal scars and opacities</td>
<td>H17.00—H17.9, A18.59</td>
</tr>
<tr>
<td>Corneal staphyloma</td>
<td>H18.721—H18.729</td>
</tr>
<tr>
<td>Corneal transplant failure</td>
<td>T86.841</td>
</tr>
<tr>
<td>Corneal transplant rejection</td>
<td>T86.840</td>
</tr>
<tr>
<td>Corneal transplant status</td>
<td>Z94.7</td>
</tr>
<tr>
<td>Corrosion of cornea and conjunctival sac</td>
<td>T26.60XA—T26.62XS</td>
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<tr>
<td>Code Descriptor</td>
<td>ICD-10 Code</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Deep vascularization of cornea</td>
<td>H16.441—H16.449</td>
</tr>
<tr>
<td>Corneal edema, other and unspecified</td>
<td>H18.20—H20.239</td>
</tr>
<tr>
<td>Displacement of other ocular prosthetic devices, implants and grafts</td>
<td>T85.328A—T85.3285</td>
</tr>
<tr>
<td>Endothelial corneal dystrophy</td>
<td>H18.51</td>
</tr>
<tr>
<td>Epithelial (juvenile) corneal dystrophy</td>
<td>H18.52</td>
</tr>
<tr>
<td>Folds and rupture in Bowman’s membrane</td>
<td>H18.311—H18.319</td>
</tr>
<tr>
<td>Graft-versus-host disease</td>
<td>D89.813</td>
</tr>
<tr>
<td>Granular corneal dystrophy</td>
<td>H18.53</td>
</tr>
<tr>
<td>Keratitis</td>
<td>H16.001—H16.079</td>
</tr>
<tr>
<td>Keratoconus, unspecified</td>
<td>H18.601—H18.629</td>
</tr>
<tr>
<td>Keratoconjunctivitis sicca, not specified as Sjögren’s</td>
<td>H16.22</td>
</tr>
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<tbody>
<tr>
<td>Keratoconus, stable</td>
<td>H18.611—H18.619</td>
</tr>
<tr>
<td>Keratoconus, unstable</td>
<td>H18.621—H18.629</td>
</tr>
<tr>
<td>Keratomalacia</td>
<td>H18.441—H18.449</td>
</tr>
<tr>
<td>Lagophthalmos</td>
<td>H02.201—H02.209</td>
</tr>
<tr>
<td>Leukocoria</td>
<td>H44.53</td>
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<tr>
<td>Mydriasis (Persistent)</td>
<td>H57.04</td>
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<tr>
<td>Other corneal scars and opacities</td>
<td>H17.89</td>
</tr>
<tr>
<td>Other hereditary corneal dystrophies</td>
<td>H18.59</td>
</tr>
<tr>
<td>Other injuries of eye and orbit</td>
<td>S05.8X1A—S05.8X9S</td>
</tr>
<tr>
<td>Other keratitis</td>
<td>H16.8</td>
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<tr>
<td>Other mechanical complication of other ocular prosthetic devices, implants and grafts</td>
<td>T85.398A–T85.398S</td>
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ICD-10-CM Codes for Medically Necessary Contact Lens Prescribing

<table>
<thead>
<tr>
<th>Code Descriptor</th>
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<tr>
<td>Other tuberculosis of eye</td>
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<tr>
<td>Penetrating wound with foreign body</td>
<td>S05.50XA—S05.52XS</td>
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<tr>
<td>Peripheral corneal degeneration</td>
<td>H18.461—H18.469</td>
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<tr>
<td>Peripheral opacity of cornea</td>
<td>H17.821—H17.829</td>
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<tr>
<td>Posterior corneal pigmentations</td>
<td>H18.051—H18.059</td>
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<tr>
<td>Presence of intraocular lens</td>
<td>Z96.1</td>
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<tr>
<td>Pupillary abnormality</td>
<td>H21.561—H21.569</td>
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<tr>
<td>Recurrent erosion of cornea</td>
<td>H18.831—H18.839</td>
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<tr>
<td>Sjögren's Syndrome</td>
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<tr>
<td>Stromal corneal pigmentations</td>
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ICD-10-CM Codes for Medically Necessary Contact Lens Prescribing

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<tr>
<td>Unspecified corneal deformity</td>
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<td>Unspecified corneal edema</td>
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<td>Unspecified corneal membrane change</td>
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<td>Unspecified corneal scar and opacity</td>
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<tr>
<td>Unspecified hereditary corneal dystrophies</td>
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<td>Unspecified injury of unspecified eye and orbit</td>
<td>S05.90XA—S05.92XS</td>
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<tr>
<td>Vitamin A deficiency with xerophthalmic scars of cornea</td>
<td>E50.6</td>
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</table>
The Prescribing Codes

GET THIS STUFF RIGHT IF YOU WANT TO GET PAID
The prescription of contact lenses includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is NOT a part of the general ophthalmological services.

The fitting of a contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.

Follow-Up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service. (92012 et seq)

The supply of contact lenses may be reported as part of the fitting. It may also be reported separately by using the appropriate supply code.”
Contact Lens Services

- 92310(4)—Prescription of Optical and Physical Characteristics of and Fitting of Contact Lens, With Medical Supervision of Adaptation; Corneal Lens, Both Eyes, Except for Aphakia
- 92311(5)—Corneal Lens for Aphakia, One Eye
- 92312(6)—Corneal Lens for Aphakia, Both Eyes
- 92313(7)—Corneoscleral Lens
- 92325—Modification of Contact Lens (Separate Procedure), With Medical Supervision of Adaptation
- 92326—Replacement of Contact Lens
- 92499—Unlisted Ophthalmological Service or Procedure
Contact Lens Services: Important Concepts

- Charge Another Contact Lens Service Fee if You Change the Lens Design “Substantially”
  - That Is, a Change That Is Not an “Incidental Revision”
- Follow Up Visits Are Not Part of the 9231x Codes. The “Supervision of Adaptation” Requirement Is Met at the First Follow-Up Visit.
- Subsequent Follow-Up Visits Are a Part of a General Ophthalmological Service—You Are Medically Evaluating the Effect of the Presence of the Contact Lens on the Ocular Tissue
Contact Lens Services—Bandage Lens

- 92070—Bandage Contact Lens Code—NO LONGER IN USE!!!! IT HAS BEEN DELETED. (I Still Get Questions On This)

- 92071—Fitting of Contact Lens for Treatment of Ocular Surface Disease
  - Do not Report 92071 in Conjunction With 92072
  - Report Supply of Lens Separately With 99070 or Appropriate Supply Code
Contact Lens Services—Keratoconus

92072—Fitting of Contact Lens for Management of Keratoconus, Initial Fitting
- For Subsequent Fittings, Report Using Evaluation and Management Services or General Ophthalmological Services
- Do not Report 92072 in Conjunction With 92071
- Report Supply of Lens Separately With 99070 or Appropriate Supply Code
HCPCS Material Codes

- V2510—Contact Lens, GP, Spherical, Per Lens
- V2511—Contact Lens, GP, Toric, Per Lens
- V2512—Contact Lens, GP, Bifocal, Per Lens
- V2513—Contact Lens, GP, Extended Wear, Per Lens
- V2520—Contact Lens, Hydrophilic, Spherical, Per Lens
- V2521—Contact Lens, Hydrophilic, Toric, Per Lens
- V2522—Contact Lens, Hydrophilic, Bifocal, Per Lens
- V2523—Contact Lens, Hydrophilic, Extended Wear, Per Lens
- V2530—Contact Lens, IP, Scleral, Per Lens
- V2531—Contact Lens, GP, Scleral, Per Lens
- V2627—Scleral Cover Shell
- V2599—Contact Lens, Other Type
Using the Unlisted Codes

- Use the “Unlisted Codes” (92499 & V2599) for Services and Materials that Are Beyond the Scope of the Other Contact Lens Prescribing Codes
- Medically Necessary Lenses in This Category
  - Hybrid Lenses
  - Hand Painted Prosthetic Lenses
  - Lenses Made from Ocular Surface Molding
- Need to Describe in Box 19
- Need Letters of Medical Necessity
Important Concepts

- The Dumbest Optometric Concept EVER!!!
  - The “Contact Lens Fitting Fee”
- The Second Dumbest Optometric Concept EVER!!!
  - The “Contact Lens Check”
- Only Use the 92071 Code for Bandage Lenses
- NCD 80.1
- NCD 80.4
Therapeutic Bandage

Some hydrophilic contact lenses are used as moist corneal bandages for the treatment of acute or chronic corneal pathology, such as bullous keratopathy, dry eyes, corneal ulcers and erosion, keratitis, corneal edema, descemetocele, corneal ectasis, Mooren's ulcer, anterior corneal dystrophy, neurotrophic keratoconjunctivitis, and for other therapeutic reasons.

Payment may be made under §1861(s)(2) of the Act for a hydrophilic contact lens approved by the Food and Drug Administration (FDA) and used as a supply incident to a physician's service. Payment for the lens is included in the payment for the physician's service to which the lens is incident. Contractors are authorized to accept an FDA letter of approval or other FDA published material as evidence of FDA approval. (See §80.4 of the NCD Manual for coverage of a hydrophilic contact lens as a prosthetic device.)
Hydrophilic contact lenses are eyeglasses within the meaning of the exclusion in §1862(a)(7) of the Act and are not covered when used in the treatment of nondiseased eyes with spherical ametropia, refractive astigmatism, and/or corneal astigmatism. Payment may be made under the prosthetic device benefit, however, for hydrophilic contact lenses when prescribed for an aphakic patient.

Contractors are authorized to accept an FDA letter of approval or other FDA published material as evidence of FDA approval. (See §80.1 of the NCD Manual for coverage of a hydrophilic lens as a corneal bandage.)
Scleral shell (or shield) is a catchall term for different types of hard scleral contact lenses. A scleral shell fits over the entire exposed surface of the eye as opposed to a corneal contact lens which covers only the central non-white area encompassing the pupil and iris. Where an eye has been rendered sightless and shrunk by inflammatory disease, a scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue. In such a case, the device serves essentially as an artificial eye. In this situation, payment may be made for a scleral shell under §1861(s)(8) of the Act.

Scleral shells are occasionally used in combination with artificial tears in the treatment of “dry eye” of diverse etiology. Tears ordinarily dry at a rapid rate, and are continually replaced by the lacrimal gland. When the lacrimal gland fails, the half-life of artificial tears may be greatly prolonged by the use of the scleral contact lens as a protective barrier against the drying action of the atmosphere. Thus, the difficult and sometimes hazardous process of frequent installation of artificial tears may be avoided. The lens acts in this instance to substitute, in part, for the functioning of the diseased lacrimal gland and would be covered as a prosthetic device in the rare case when it is used in the treatment of “dry eye.”
Patient Management Issues

- Have Your Staff Confirm Eligibility and Reimbursements PRIOR to the Patient Coming In Whenever Possible
- Match Appropriate ICD-9/10-CM Diagnostic Codes to the Appropriate CPT and HCPCS Service Codes
- Use a Patient Brochure to Explain the Process of Prescribing Medically Necessary Contact Lenses
- Send Letters of Medical Necessity When Needed (Have them Already Written in Document Templates)
  - Some Private Carriers Require LMN’s
  - When Using the -22 Modifier—Always
July 3, 2012

Insurance Management Services
PO Box 13088
Amarillo, TX 79103

Re: Letter of Medical Necessity for Patient John Doe, Insured # 123456789

To Whom It May Concern:

I have examined Mr. Doe, who has Keratoconus, Stable Condition (CPT Code 97143), and who, according to the 1996 American Medical Association "Definition of Medical Necessity," qualifies for medically necessary contact lenses. It is, therefore, medically necessary for Mr. Doe to wear RG7 Conal Contact Lenses. I write this letter for review of benefits under Mr. Doe’s plan for the provision of contact lenses that are therapeutic and not cosmetic.

The service code (CPT) for this diagnosis is:

92732: Fitting of Contact Lens for Management of Keratoconus, Initial Fitting
The fee for this service is $160.00

The service code (HCPCS) for this diagnosis is:

V5931: Contact lens, gas permeable, spherical, per pair (Two lenses will be needed)
The fee for these lenses is $600.00 for each lens.

Please contact me immediately about Mr. Doe’s available benefits, or if you have any questions.

Sincerely,

[Signature]

Clarke D. Newman, OD, FAAO

[Address]

[Phone Number]
Documentation

- Remember, All Documentation Should Support Your Diagnosis and Treatment Plan
- Each Test Must Be Rational to the Differential Diagnosis As Guided by the Chief Complaint
- Failure To Document Fully the Chief Complaint, the Associated HPI, the Objective Testing (Including the Order, the Interpretation, and Clinical Decision Making), The CL Diagnostic Evaluation and Results May Result in a Failed Audit
Clinical Examples

Let's walk through one or two of these cases.
A Keratoconus Patient

- A 33 y/o, White, Male
- Referred By Another OD With a Dx of Keratoconus X 5 yrs
  Transfer of Care Implied
- CC: Multiple CL Failures
  - HPI: Worn Corneal RGP’s, Maintains Less Than Three Hours of Lens Wear
- Hx: Otherwise Unremarkable
Billing for the Initial Visit*

- Dx: ICD-10-CM: H18.603—Keratoconus, Unspecified, Bilateral

- 99205—E/M, Level 5, New Patient $228.14
- 92015-22—Refraction, Complex $ 52.00
- 92285—External Photography $ 22.72
- 76514—Pachymetry $ 16.85
- 92025—Corneal Topography $ 42.17
- 92286—Specular Microscopy $ 42.58
- 92499-RT—Abberometry $ 40.00
- 92499-LT—Abberometry $ 40.00
- 92072—Prescribing for Keratoconus $150.42
- 92072—Prescribing for Keratoconus $150.42
- V2599—Contact Lens, Other Type, per lens (2) $440.00 (Ultra Health®)
- V2599—Contact Lens, Other Type, per lens (2) $440.00 (Ultra Health®)

Total $1,665.30

* 2016 Limiting Charges for Jurisdiction H, Texas, Locality 11
An Anisometropia Patient

- A 25y/o, White, Female, Established Patient
- CC: Eye Strain With Glasses
  - HPI: Also Poor Depth Perception
- Hx: Otherwise Unremarkable
- Manifest Refraction
  - OD: -5.00 - 3.75 X 140  20 / 25+2
  - OS: -3.50 – 1.75 X 034  20 / 20+1
- Corneal Curvature
  - OD: 48.00 / 51.00 @ 037
  - OS: 42.00 / 43.00 @ 127
Billing for the Initial Visit*

- **Dx:** ICD-10-CM: H52.31—Anisometropia

- 99214—E/M, Level 4, Established Patient $118.80
- 92015-22—Refraction, Complex $52.00
- 92025—Corneal Topography $42.17
- 92286—Specular Microscopy $42.58
- 92499-RT—Abberometry $40.00
- 92499-LT—Abberometry $40.00
- 92313-RT—Prescription of Optical and Physical Characteristics of and Fitting of Contact Lens, With Medical Supervision of Adaptation; Corneoscleral $175.00
- 92313-LT-52—Prescription of Optical and Physical Characteristics of and Fitting of Contact Lens, With Medical Supervision of Adaptation; Corneoscleral $87.50
- V2521—Contact Lens, Hydrophilic, Toric, Per Lens $48.00**
- V2521—Contact Lens, Hydrophilic, Toric, Per Lens $48.00**

** If Quarterly Replacement, 8 Units Will Be Billed

Total $982.05

*2016 Limiting Charges for Jurisdiction H, Texas, Locality 11
Vision Care Plan MNCL Benefits

Know these procedures or pay the price
Vision Care Plans (VCP’s)

- Vision Service Plan (VSP)
- EyeMed (EM)
- Vision Benefits of America (VBA)
- Davis Vision
- Spectera
VSP: Necessary Contact Lenses

- Look in the 2016 Manual
  - Go to www.eyefinity.com, and log in
  - Click “VSPOnline” Down the Right-Hand Side
  - Click “Manuals” Down the Left-Hand Side
  - Click “VSP”
  - Under “Plans and Coverage,” Click “Contact Lens Benefits”
  - Scroll Down to “Visually Necessary Contact Lenses”
  - Print the PDF Version and Keep It Available to Answer Questions
VSP: Qualified Diagnoses

- Aphakia
- Nystagmus
- Keratoconus
- Aniridia
- Cornea Transplant
- Hereditary Corneal Dystrophies
- Anisometropia $\geq 3.00$ D in Any Meridian
- Ammetropia $\geq 10.00$D in Any Meridian
- Irregular Astigmatism
VSP: Qualified Diagnoses

- Achromatopsia
- Albinism
- Polychoria, Anisocoria (congenital)
- Pupillary Abnormalities
VSP: Necessary Contact Lenses

- File on eClaim
- For Anisometropia and High Ammetropia, Provide the Spectacle Rx
- For Scleral Lenses, Use HCPCS V2531
  - Do not use the V2530; only use the V2531
- Bill Hybrid Lenses With HCPCS V2599
- For Scleral and Hybrid Lenses, Provide the Brand and Type in Box 19
  - State Whether or not the Lens is a “Scleral” or Hybrid
  - Provide the Manufacturer and the Brand
- Use the V2599 for Lenses that Do Not Have a HCPCS Code
  - Hand Painted Lenses, etc
VSP: Necessary Contact Lenses

- Piggyback Benefit is Available for a Patient Who Meets the Previously Discussed Criteria, and Who is Intolerant of GP Lenses
  - Provide Information on Piggyback Lens in Box 19
- Spectacle Lenses to Wear Over Contacts Benefit
  - Aphakia (379.31, 743.35)
  - High Ammetropia ≥ 10.00D
  - Presbyopia (367.4)
  - Accommodative Disorder
  - Binocular Function Disorder
  - Different Prism Requirements for Distance and Near
  - Prescription Required
  - Call VSP (800-615-1883) for Claim Number
  - 30 Day Time Limit
- 85% of Usual and Customary Charges for “Contact Lens Exam Services (Fitting and Evaluation)”
VSP: Necessary Contact Lenses

- The Basic Examination Is Billed and Payable per the Terms of the Plan
- VSP Reimburses 85% of Usual and Customary Charges for “Contact Lens Exam Services (Fitting and Evaluation)”
- VSP Reimburses Usual and Customary Fees for Materials Up To the Plan Limits
  - Two Schedules on Plan Limits
    - Covered and Base Visually Necessary CL Maximums
    - Visually Necessary CL Specialty Maximums
      - Service Driven or Diagnosis Driven (See Chart)
      - Must Bill 92072, 92311, or 92312 or One of the Diagnoses
- The Patient Is Responsible for Exam and Material Copayments
## VSP: Necessary Contact Lenses

### Covered and Base Visually Necessary Contact Lens Maximums

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Annual Replacement</th>
<th>Planned Replacement</th>
<th>Daily Replacement</th>
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<tr>
<td>V2500*</td>
<td>$251</td>
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<td>V2501*</td>
<td>$251</td>
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<tr>
<td>V2502*</td>
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<td>V2503*</td>
<td>$491</td>
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<td>V2510*</td>
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<td>V2522</td>
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<td>$650</td>
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<td>V2523</td>
<td>$537</td>
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<tr>
<td>V2599**</td>
<td>$987</td>
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<tr>
<td>Piggyback</td>
<td>$1,150</td>
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## VSP: Necessary Contact Lenses

### Visually Necessary Contact Lens Specialty Maximums

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<th>Annual Replacement</th>
<th>Planned Replacement</th>
<th>Daily Replacement</th>
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<tbody>
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<td>V2599**</td>
<td>$1,300</td>
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<tr>
<td>Piggyback</td>
<td>$1,300</td>
<td>$1,650</td>
<td>—</td>
</tr>
</tbody>
</table>
VSP: Necessary Contact Lenses

1Annual Replacement is 1-2 units. Planned Replacement is 3-360 units. Daily Replacement is 361+ units.
*These services shouldn’t be billed for more than 2 units. If billed with higher unit counts, we’ll pay up to the Annual Replacement lens maximum.
**These services shouldn’t be billed for more than 360 units. If billed with higher unit counts, we’ll pay up to the Planned Replacement lens maximum.
***Effective 2/6/2012, maximum reimbursement increased to $2,300. For dates of service between 10/1/2011 and 2/5/2012 maximum reimbursement is $1,300.
****As of 7/16/2012, V2520, V2521, and V2522 with units of 361+ are not covered under the Specialty Maximums. For dates of service between 10/1/2011 to 7/15/2012 maximum reimbursement is: V2520= $698; V2521= $833; V2522= $950.
EyeMed: Necessary Contact Lenses

- Go to portal.eyemedvisioncare.com
- Click on “Providers”
- Click on “Login / Register”
- Click on “Manuals”
- Click on “Section 9: Special Services”
- Download the PDF for Section 9
EyeMed: Necessary Contact Lenses

- Anisometropia ≥ 3.00D
- High Ametropia ≥ +/- 10.00D
- Keratoconus Where the BCVA Through Spectacles is Worse than 20/25
- Where CL’s can improve BCVA Two or More Lines Compared to Spectacles
- Pediatric Aniridia (CA Only)
- Pediatric Aphakia (CA Only)
- Pediatric Corneal Disorder or Post-Traumatic Disorder (CA Health Net)
- Pediatric Pathological Myopia (CA Health Net)
EyeMed: Necessary Contact Lenses

- One Benefit Per Calendar Year
- Call (888) 581-3648 for Authorization
- Report on a EyeMed Necessary Contact Lens Form (Download) and FAX to 866-293-7373
## EyeMed: Necessary Contact Lenses

<table>
<thead>
<tr>
<th>Qualifying Criteria</th>
<th>Contracted Provider Reimbursement</th>
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</thead>
<tbody>
<tr>
<td>Anisometropia</td>
<td>95% of U&amp;C up to $700</td>
</tr>
<tr>
<td>High Ammetropia</td>
<td>95% of U&amp;C up to $700</td>
</tr>
<tr>
<td>Keratoconus</td>
<td>95% of U&amp;C up to $1,200</td>
</tr>
<tr>
<td>Vision Improvement</td>
<td>95% of U&amp;C up to $2,500</td>
</tr>
<tr>
<td>Qualifying Criteria</td>
<td>Contracted Provider Reimbursement</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Pediatric Aniridia</td>
<td>95% of U&amp;C up to $3,730</td>
</tr>
<tr>
<td>Pediatric Aphakia</td>
<td>95% of U&amp;C up to $5,800</td>
</tr>
<tr>
<td>Pediatric Corneal &amp; Post-Trauma Disorder</td>
<td>95% of U&amp;C up to $2,500</td>
</tr>
<tr>
<td>Pediatric Pathological Myopia</td>
<td>95% of U&amp;C up to $700</td>
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</tbody>
</table>
# EyeMed: Necessary Contact Lenses

<table>
<thead>
<tr>
<th>Qualifying Criteria</th>
<th>Non-Standard Medically Necessary Contact Lens Codes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anisometropia</td>
<td>92310AN</td>
</tr>
<tr>
<td>High Ametropia</td>
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<tr>
<td>Keratoconus</td>
<td>92072</td>
</tr>
<tr>
<td>Vision Improvement</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric Aniridia</td>
<td>92310AI</td>
</tr>
<tr>
<td>Pediatric Aphakia</td>
<td>92310AP</td>
</tr>
<tr>
<td>Pediatric Corneal Post-Trauma Disorder</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric Pathological Myopia</td>
<td>92310PM</td>
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</tbody>
</table>
**EyeMed Medically Necessary Contact Lenses Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Patient</td>
<td>[Patient Name]</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>[Date of Birth]</td>
</tr>
<tr>
<td>Prescriber Name</td>
<td>[Prescriber Name]</td>
</tr>
<tr>
<td>Diagnose Code</td>
<td>[Diagnose Code]</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>[Medical Condition]</td>
</tr>
<tr>
<td>Contact Lenses Type</td>
<td>[Contact Lenses Type]</td>
</tr>
<tr>
<td>Doctor's Signature</td>
<td>[Signature]</td>
</tr>
<tr>
<td>Date</td>
<td>[Date]</td>
</tr>
</tbody>
</table>

For more detailed information, please refer to the form.
# EyeMed Medically Necessary Contact Lenses Form

**Patient Information (Required)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Birth Date (MM/DD/YYYY)</th>
<th>Telephone Number (with area code)</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Member ID # (if applicable)</th>
<th>Relationship to the Subscriber</th>
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<td>Subscriber: ❑</td>
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**Subscriber Information (Required)**

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<th>Middle Initial</th>
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<table>
<thead>
<tr>
<th>Vision Plan Name</th>
<th>Vision Plan/Group #</th>
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<table>
<thead>
<tr>
<th>Date of Service (Required) (MM/DD/YYYY)</th>
<th>Authorization #</th>
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<tbody>
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</table>
# EyeMed Medically Necessary Contact Lenses Form

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Description</th>
<th>Benefits</th>
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</thead>
<tbody>
<tr>
<td>Corneal Abrasion</td>
<td>K7000</td>
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<td></td>
</tr>
<tr>
<td>Peripheral Ulcer</td>
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<tr>
<td>Pterygium</td>
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</tr>
<tr>
<td>Ectropion</td>
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</tr>
<tr>
<td>Entropion</td>
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<tr>
<td>Conjunctivitis</td>
<td>K8000</td>
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</tbody>
</table>

**Instructions:**

- Complete all sections of the form.
- Attach supporting documentation as required.
- Submit form to EyeMed for review.

**Contact Information:**

- EyeMed Customer Service: 1-800-633-8999
- EyeMed Provider Services: 1-800-327-8800

**Additional Resources:**

- Guidelines for Medically Necessary Contact Lenses: [Link](https://example.com)
- Form Instructions: [Link](https://example.com)

**Effective Date:** [Date]
Other Billing Considerations

- Know Your Chair Costs (Nov, 2008 Spectrum)
- Know How Much Time It Takes to Prescribe, Order, Receive, Dispense, Instruct, and Follow Through Adaption Each Type of Specialty Lens
- Add Your Profit for a Rational and Defensible Initial Dispensing Fee
- Charge for Follow Up Visits After That
- Know the Lens Cost, Number of Lenses Per Eye It Takes to Achieve Success, the Return Policy, and the Delivery Cost of Each Lens
- Add Your Profit for a Rational and Defensible Lens Fee
The Gross Per Patient Visit for Prescribing Specialty Contact Lenses, Especially Medically Necessary Lenses, Is Nearly Twice the National Average for All Other Types of Eye Care

These Patients Need Glasses Also

These Patients Have Other Medical Conditions Also

- Glaucoma
- Dry Eye
- Macular Degeneration
Conclusions

- Know What the Contracts Say For Each Contract for Each Code That You Use in Your Office
- Use the Correct Codes and Modifiers to Maximize the Reimbursement for the Services Rendered
- Bill Appropriately for All of Your Services—Forget About “Fitting Fees”
- Make Sure That Your Fees Are in Line With the Contracts That You Have Signed, But High Enough to Be Commensurate With the Complexity, Time, and Liability Involved
- Learn to Consult With Your Colleagues—It Won’t Hurt One Bit
- Learn to Promote This Aspect of Your Practice
Conclusions

- Be Consistent
- Having the Right Tools—Know where to Find the Information, i.e., Code Books, Contracts, etc.
- Don’t Be a Slave to Third Party Payers—You Decide What Tests and Procedures Need to Be Done; They Decide What They Will Pay For
- Communicate With Your Patients
- Don’t Be Afraid to Appeal Rejections or Send Third Party Payers to Collection (Be Careful About the Arbitration Agreements in Your Contracts)
Thank You!

ANY QUESTIONS?

CDNEWMAN@EARTHLINK.NET