



KANSAS MEDICAL ASSISTANCE PROGRAM

Provider Manual

Vision

PART II VISION PROVIDER MANUAL

Introduction

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FORMS All forms pertaining to this provider manual can be found on the public website at <https://www.kmap-state-ks.us/Public/forms.asp> and on the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp> under Pricing and Limitations.

PART II

VISION PROVIDER MANUAL

Updated 12/11

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to vision providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection gives information on the billing form applicable to vision services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of vision services allowed within **KMAP**.

The **Appendix** subsection contains information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

HIPAA Compliance

As a participant in **KMAP**, providers are required to comply with compliance reviews and complaint investigations conducted by the secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. VISION BILLING INSTRUCTIONS Updated 12/11

Introduction to the CMS-1500 Claim Form

Vision providers must use the red CMS-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under KMAP. Any CMS-1500 claim form not submitted on the red claim form will be returned to the provider. An example of the CMS-1500 claim form is available:

- On the public website at <https://www.kmap-state-ks.us/Public/forms.asp>
- On the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp>.

The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information must be submitted in the correct claim fields to be recognized by the equipment.

The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to Section 1100 of the *General Introduction Provider Manual*.

Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the *General Billing Provider Manual*.

SUBMISSION OF CLAIM

Send completed first page of each claim and any necessary attachments to:

Office of the Fiscal Agent

P.O. Box 3571

Topeka, Kansas 66601-3571

7020. VISION SPECIFIC BILLING INFORMATION Updated 12/10

Complete the CMS-1500 claim form if the vision services meet the following criteria:

- The services provided are all professional (no material charges).
- The services are both professional and materials and the provider receives the payment for materials.

An invoice is **not** required.

Diagnosis Codes

Applicable ICD-9 diagnosis codes are required on all claims submitted for processing. Opticians and optometrists should share these codes with the dispenser.

Cataract Surgery

If vision services such as eye exams, lenses, or frames are being rendered due to cataract surgery (diagnosis codes 366.50-366.53, 379.31) or lens replacement (diagnosis code V43.1), the date of surgery must be present in field 19 of the CMS-1500 claim form. If the date of surgery is not present, the services will be denied.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 12/10

Vision services require a copayment of \$2 per date of service. Refer to Section 3000 of the *General Third Party Liability Payment Provider Manual* for exceptions.

Bill all services occurring on the **same** date on the **same** claim form.

If multiple claims are submitted for the same date(s) of service, the copayment requirement will be deducted for each claim submitted.

Do **not** reduce charges or balance due by the copayment amount. This reduction will be made automatically during claim processing.

BENEFITS AND LIMITATIONS

8300. Benefit Plan Updated 12/10

KMAP beneficiaries will be assigned to one or more benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 12/10

Eye Exams

One complete eye exam is covered every four years when provided by ophthalmologists and optometrists for non-KAN Be Healthy (KBH) beneficiaries. Eye exams are covered as needed up to one year following cataract surgery when provided by ophthalmologists and optometrists. Eye exams are limited to one every four years; however, a total of two eye exams are covered per month to detect and/or follow medical conditions.

Eye exams are covered as needed for KBH beneficiaries when provided by ophthalmologists and optometrists. The following basic eye exam procedure codes are considered KBH vision screens: 92002, 92004, 92012, 92014, and 99173.

Since ophthalmologists and optometrists provide more extensive eye examinations than are reflected by a KBH vision screening code, these vision providers must bill vision exams using one of the codes listed in the appendix of this manual.

Refraction (92015) is not included in a basic eye exam. Refractions may be provided on the same date of service as the basic eye exam and billed as a separate procedure.

If visual field examinations, fundus photography, and laser scanning are performed on the same date of service as an eye exam, visual field examinations, fundus photography, and laser scanning are considered content of service of that eye exam unless medical necessity is shown.

Visual field examinations and laser scanning are not allowed on the same date of service. Both procedures are limited to a total of four times per 365 days if medical necessity is present. (Laser scanning is limited to four per year. Modifier LT or RT is no longer required when billing laser scanning.)

Visual field testing must be medically necessary to establish a diagnosis, monitor a course of treatment, or determine if a change in therapeutic plan is necessary because of a progression of a disease. Furthermore, the lowest level of testing medically necessary should be used. Glaucoma is the most frequent diagnosis associated with visual field testing. Visual field testing may be medically necessary in a glaucoma suspect or a patient with glaucoma, mild damage, and good control only once every year. Visual field testing may be necessary in patients with moderate glaucoma and good control once a year. Field testing may be necessary in mild, moderate, or advanced glaucoma and borderline control two times a year. Finally, visual field testing in patients with advanced damage or uncontrolled glaucoma may be necessary up to four times a year.

Fundus photography and visual field examinations are considered content of service of an eye exam when performed on the same date of service unless the diagnosis on the claim clearly supports medical necessity for the procedure.

8400. MEDICAID Updated 12/10

Eye Exams continued

Laser scanning is appropriate once a year to follow preglaucoma patients or those with mild damage. Patients with moderate damage may be followed with either scanning or visual field testing. Using scanning **and** visual field testing is not allowed. Patients with moderate damage may be followed with two tests per year. If the glaucoma is uncontrolled, more than two tests per year (up to the limit of four tests) may be necessary. Finally, in advanced damage, visual field testing is preferred instead of laser scanning.

Corneal topography is allowed no more than one time per year with prior authorization. Medical necessity must be shown by one of the following diagnosis codes: 371.46, 371.48, 371.60, 371.61, 371.62, 996.51, and V42.5. Corneal topography is noncovered for preparation or continued care of Laser-Assisted in Situ Keratomileusis (LASIK) surgery or basic fitting or refitting of contact lenses.

LASIK surgery is noncovered.

Documentation

Documentation in the beneficiary's medical record must support the service billed in the course of a postpayment review. Refer to Section 2700 of the *General Benefits Provider Manual* for KMAP documentation requirements.

Eyeglasses

All frames must include a one-year warranty.

Backup eyeglasses are noncovered and should not be billed to KMAP.

Eyeglasses may initially be ordered on the same date a KBH vision exam is performed.

The fitting of new eyeglasses is considered content of service of the charge for the glasses and cannot be billed separately.

Eyeglasses are covered up to no more than three sets of lenses and three pairs of frames per 365 days for KBH beneficiaries. Replacement parts may be covered.

Eyeglasses are covered up to no more than one set of lenses and one pair of frames per 1,460 days (four years) for non-KBH beneficiaries.

If only one lens or just frames are issued to the non-KBH participant after the four-year limitation, the patient remains eligible to receive the other lens and/or frames. The provider needs to verify with Customer Service at 1-800-933-6593 to determine if the beneficiary qualifies for further coverage before billing the KMAP beneficiary. Minor repairs to eyeglasses may be covered.

The date of receipt of the prescription (ordering date) is considered the date of service. The provider may bill KMAP before the actual dispensing of the glasses since the intent to render service has been confirmed by the acceptance of the prescription.

8400. MEDICAID Updated 12/10

Eyeglasses continued

Optometrists and ophthalmologists who provide eyeglass dispensing services to non-KMAP beneficiaries must offer this service to KMAP beneficiaries. This policy is monitored on a postpayment basis.

If a beneficiary chooses eyeglass frames or lenses that exceed KMAP's allowed amount, the beneficiary is responsible for the entire expense of the frames or lenses. Do not bill KMAP for these services.

Eyeglasses for postcataract surgery patients are covered when provided within one year following the cataract surgery.

All sunglasses, transition lenses, tints (including photochromatic), progressive lenses, safety glasses, and athletic glasses are noncovered.

Polycarbonate lenses are covered with medical necessity. Polycarbonate lenses are billed using one of the following options:

- V2784 (This code is NOT in addition to and cannot be billed with any other lens codes.)
- S0580 (List this code in addition to the basic code for the lens. If using S0580, providers should bill this code in addition to the appropriate lens code.)

Codes V2784 and S0580 cannot be billed together. Polycarbonate lenses are noncovered for convenience or cosmetic reasons. Modifier 22 is no longer required. If a beneficiary chooses polycarbonate lenses when medical necessity does not exist, the beneficiary is responsible for the entire cost of the lens.

Contact Lenses

Prior authorization is required at all times for contact lens services. Backdating a prior authorization is not allowed. Providers must obtain a prior authorization approval from KMAP before dispensing contacts.

The following beneficiary information must be provided with a prior authorization request:

- Eyeglass lens prescription and the visual acuity achieved with this correction in both eyes
- Visual acuity without correction
- Type of contact lenses to be fitted
- Date of original fitting
- Reason for refitting, if applicable
- Medical necessity for contact lenses
- Outline of adaptation procedures
- Probability of need for supplemental eyeglass lenses
- Approximate cost to KMAP

8400. MEDICAID Updated 12/10

Contact Lenses continued

Contact lenses and replacements are covered with prior authorization for the following (medical necessity must be present):

- Monocular aphakia
- Bullous keratopathy
- Keratoconus
- Corneal transplant
- Anisometropia of more than three diopters of difference that is causing vision distortion and cannot be corrected with glasses
- Anisekonia of more than three diopters of difference that is causing vision distortion and cannot be corrected with glasses

Contact lens adaptation includes six months of care.

Contact lens replacement includes neutralization per lens.

Contact lenses are noncovered for cosmetic purposes or for athletic participation. Contact sunglasses, colored or tinted of any kind, are noncovered.

Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Blepharoplasty and Blepharoptosis

Blepharoplasty and Blepharoptosis procedures require prior authorization. The beneficiary must meet the following criteria:

- Margin Reflex Distance (MRD) must be 1.0 or less in the best eye.
- Full Flash Photo light reflex must be performed to identify papillary center resting tangent.
- Visual field loss must be 10-15 degrees above dead center in the best eye for beneficiaries 14 years of age and older. Submit with request visual field loss of both eyes (taped and untaped).
- Prior vision history and expected outcomes of surgery must be submitted with request.
- If best eye does not meet the above criteria, the surgery is not allowed except in beneficiaries less than 10 years of age.
- For coverage of one eye, the same criteria applies unless person only has one functional eye.
- For coverage of both eyes, the best eye must meet all of the above criteria.
- All of the above information must be submitted at the time the prior authorization request is made. Requests cannot be processed without all of the above information.

8400. MEDICAID Updated 12/10

Vision Therapy

Orthoptic and/or pleoptic training (also referred to as vision therapy) is a noncovered KMAP benefit. No services are payable arising from the assessment, planning, implementation, or evaluation of vision therapy.

Emergency Medical Services for Aliens (SOBRA)

In addition to inpatient hospital and emergency room hospital, emergency services performed in outpatient facilities and related physician, lab, and x-ray services will be allowed for the following places of service: office, outpatient hospital, federally qualified health clinics, state or local public health clinics, rural health clinics, ambulance, and lab for SOBRA claims. Inpatient hospital reimbursement will not be limited to 48 hours. Follow-up care will not be allowed once the emergent condition has been stabilized.

Refer to Section 2040 of the *General Benefits Provider Manual* for specific information.

APPENDIX CODES

Updated 12/11

The following codes represent an all-inclusive list of vision services billable to KMAP. Procedures not listed here are considered noncovered. Refer to Section 8400 of this manual for additional benefits and limitations.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information from the public website is available at:
<https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>.
- Information from the secure website is available under Pricing and Limitations after logging on at: <https://www.kmap-state-ks.us/provider/security/logon.asp>.

A chart has been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers chart is available on both the [public](#) and [secure](#) websites. It is under Reference Codes on the main provider page and Pricing and Limitations on the secure portion. Information on the American Medical Association is available at <http://www.ama-assn.org>.

COVERAGE INDICATORS

KBH - KAN Be Healthy participation is required.
PA - Prior authorization is required.
C - Covered KMAP service.

PROFESSIONAL SERVICES **EYE EXAMINATIONS**

C 92002	C 92004	C 92012	C 92014
C 92015	C 92020	C 92081	C 92082
C 92083	C 92100	C 92132	C 92133
C 92134	C, PA 92025	C 92140	C 92250
C 92285			

LENSES, FRAMES, AND MATERIALS

C V2020	C V2100	C V2101	C V2102
C V2103	C V2104	C V2105	C V2106
C V2107	C V2108	C V2109	C V2110
C V2111	C V2112	C V2113	C V2114
C, PA V2115	C, PA V2118	C, PA V2121	C, PA V2199
C V2200	C V2201	C V2202	C V2203
C V2204	C V2205	C V2206	C V2207
C V2208	C V2209	C V2210	C V2211
C V2212	C V2213	C V2214	C, PA V2215
C, PA V2218	C V2219	C V2220	C, PA V2221
C V2299	C V2300	C V2301	C V2302
C V2303	C V2304	C V2305	C V2306
C V2307	C V2308	C V2309	C V2310
C V2311	C V2312	C V2313	C V2314

APPENDIX

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LENSES, FRAMES, AND MATERIALS continued

C, PA V2315	C, PA V2318	C V2319	C V2320
C, PA V2321	C V2399	C, PA V2410	C, PA V2430
C, PA V2499	C V2710	C V2715	C V2760
C V2782	C V2783	C V2784	C, PA V2799
C 92370	C S0580		

CONTACT LENS ADAPTATION

C, PA 92070	C, PA V2521	C, PA V2522	C, PA V2523
C, PA 92071	C, PA V2531	C, PA S0500	C, PA 92312
C, PA 92072	C, PA 92310	C, PA 92311	C, PA 92316
C, PA 92313	C, PA 92314	C, PA 92315	C, PA V2500
C, PA 92317	C, PA 92325	C, PA 92326	C, PA V2510
C, PA V2501	C, PA V2502	C, PA V2503	C, PA V2520
C, PA V2511	C, PA V2512	C, PA V2513	C, PA V2530

ARTIFICIAL EYES

(Includes both professional and material charges)

C V2623	C V2624	C V2625	C V2626
C V2627	C V2628		