VISION SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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TEXAS
Health and Human
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VISION SERVICES

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40.1 Enrollment

To enroll in the CSHCN Services Program, ophthalmologists, optometrists, and opticians are required to be actively enrolled in Texas Medicaid. They must have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Optometrists, ophthalmologists, and opticians may enroll either as an individual or as a group with performing providers. Opticians may also enroll as a facility. Out-of-state ophthalmologist, optometrists, and optician providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC) Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

40.2 Benefits, Limitations, and Authorization Requirements

Vision related services are a benefit of the CSHCN Services Program. The CSHCN Services Program may consider the following services for reimbursement:

- Vision eye exams with refraction
- Other eye exams for medical reasons
- Medical eye treatments
- Frames
- Lenses
- Contact lenses
- High-power lenses
- Scleral lenses
- Repair and replacement of frames and lenses
- Other medically necessary vision services

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The following services are not benefits of the CSHCN Services Program:

- Eyeglasses that do not significantly improve visual acuity or that do not impede the progression of visual problems
- Plano sunglasses
- Optional eyeglass features that are requested by the client but that do not increase visual acuity, such as tinting, decorative accessories or lettering, or eyeglass cases
- Polarization of lenses
- Extended color vision examination
- Dark adaptation examination
- Vision screening
- Contact lenses that correct color vision deficiency
- Services and procedures that are investigational or experimental
- Low vision aids

Note: *Clients in need of low vision aids may be referred to the Texas Health and Human Services Commission (HHSC) Division for Blind Services (DBS) for consideration of coverage.*

Vision services are a benefit when provided by ophthalmologists, optometrists, and opticians practicing according to standards established by their licensing boards and the state laws of Texas.

40.2.1 Frames, Lenses, and Contact Lenses

40.2.1.1 Frames

Providers must offer frames that meet the following criteria:

- A choice of at least three styles that are appropriate to the client's age or gender
- Frames in sizes that are appropriate to the client's needs
- A choice of at least three colors

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of fabricated and finished spectacle lenses, frames, or other ophthalmic devices prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

Frames must be composed of all zylonite components, meet statutory quality standards, and be made of new materials. Clients or families may only choose frames that are metal or a combination of zylonite and metal if they are willing to pay the difference between the CSHCN Services Program's reimbursement for frames and the cost of metal or metal and zylonite frames.

Providers may submit procedure codes V2020 and V2025 for the reimbursement of eyeglass frames.

40.2.1.2 Eyeglass Lenses

Lenses must meet the American National Standards Institute (ANSI) specifications (see www.ansi.org) for first quality prescription ophthalmic lenses, including, but not limited to, the following:

- Lenses must be made of clear glass or plastic.
- Lenses must be composed of new materials.
- Bifocals must be flat-tops or an equivalent style with a near segment of at least 25 mm width.
- Trifocals must be flat-tops or an equivalent style with an intermediate segment of at least 7 X 25 mm.

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Providers may submit the following procedure codes for the reimbursement of eyeglass lenses. Providers must bill with a quantity of two when billing for bilateral lenses with the same prescription.

Single Vision Lenses Procedure Codes								
V2100	V2101	V2103	V2104	V2107	V2108	V2115	V2118	V2121

Bifocal Lenses Procedure Codes									
V2200	V2201	V2203	V2204	V2207	V2208	V2215	V2218	V2219	V2220
V2221									

Trifocal Lenses Procedure Codes									
V2300	V2301	V2303	V2304	V2307	V2308	V2315	V2318	V2319	V2320
V2321									

40.2.1.3 Special Eyeglass Lenses

Special lenses, such as high-index, polycarbonate, and high-powered lenses, are a benefit of the CSHCN Services Program if they are ordered by the treating physician because they are medically necessary and not solely because of a client's preference.

- High-power lenses have a sphere greater than 7.00 diopters or a cylinder greater than 4.00 diopters.
- High-index lenses allow lighter-weight lenses for clients who have unusually heavy lenses.
- Polycarbonate lenses are considered the standard for children's eyewear because polycarbonate provides extra strength, flexibility, and inherent UV protection.

Ophthalmologists, optometrists, and opticians may submit the following procedure codes for the reimbursement of special eyeglass lenses:

High-Power Lenses Procedure Codes									
V2102	V2105	V2106	V2109	V2110	V2111	V2112	V2113	V2114	V2202
V2205	V2206	V2209	V2210	V2211	V2212	V2213	V2214	V2302	V2305
V2306	V2309	V2310	V2311	V2312	V2313	V2314			

The following procedure codes will not be reimbursed unless billed with the appropriate lens procedure code by the same provider for the same date of service:

Procedure Codes for Add-On Lenses				
V2410	V2430	V2715	V2755	V2784

Procedure codes V2410, V2430, V2715, V2755, and V2784 will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

Ultraviolet (UV) lenses (procedure code V2755) may be reimbursed when billed with a diagnosis of aphakia. UV lenses will be denied when billed for the same date of service as polycarbonate lenses (procedure code V2784).

40.2.1.4 Contact Lenses

Dispensing of contact lenses includes the fabrication, ordering, adjustment, dispensing, sale, and delivery to the client of the contact lenses prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

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Contact lenses that are made of hydrophilic and rigid materials are a benefit of the CSHCN Services Program.

- Hydrophilic contact lenses that have been reviewed by the U.S. Food and Drug Administration (FDA) and released for sale in the U.S. will be considered for reimbursement only for those uses for which they have been reviewed.
- Hard and gas permeable lenses must conform to the ANSI requirements for first quality contact lenses.

Examinations for contact lens prescriptions and fittings include:

- The specific optical and physical characteristics of the contact lens including power, size, curvature, flexibility, and gas-permeability.
- Medically necessary tests including multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, and initial tolerance evaluation.
- The instruction and training of the client and incidental revision during the training period.
- Follow-up care for a period of six months.

Fitting and modification of contact lenses may be reimbursed to providers using the following procedure codes:

Contact Lens Fitting Exam Procedure Codes									
92310	92311	92312	92313	92314	92315	92316	92317	92325	92326

Providers may submit the following procedure codes with a quantity of two for the reimbursement of a pair of contact lenses:

Contact Lens Procedure Codes									
V2500	V2501	V2502	V2510	V2511	V2512	V2513	V2520	V2521	V2522
V2523	V2530	V2531	V2599						

Contact lenses and their prescription and fitting are limited to the following diagnosis codes:

Diagnosis Codes							
H18601	H18602	H18603	H18611	H18612	H18613	H18621	H18622
H18623	H2701	H2702	H2703	H27111	H27112	H27113	H27121
H27122	H27123	H27131	H27132	H27133	H35101	H35102	H35103
H35141	H35142	H35143	H35151	H35152	H35153	H35161	H35162
H35163	H35171	H35172	H35173	H4421	H4422	H4423	H442A1
H442A2	H442A3	H442A9	H442B1	H442B2	H442B3	H442B9	H442C1
H442C2	H442C3	H442C9	H442D1	H442D2	H442D3	H442D9	H442E1
H442E2	H442E3	H442E9	H5201	H5202	H5203	H5211	H5212
H5213	H52201	H52202	H52203	H52211	H52212	H52213	H52221
H52222	H52223	H5231	H5232	H524	H53001	H53002	H53003
H53011	H53012	H53013	H53021	H53022	H53023	H53031	H53032
H53033	H53041	H53042	H53043	H53049	Q123	Q134	Z961

Scleral lenses that are prescribed as a liquid bandage must be billed using procedure code S0515. Scleral lenses that are used therapeutically in other ways should be billed using procedure code V2530 or V2531. Reimbursement for scleral lenses requires authorization.

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Refer to: Section 40.2.1.6.2, "Scleral Lenses and Liquid Bandages" in this chapter for detailed information on prior authorization requirements

Providers may bill for the replacement of contact lenses under current prescription due to damage or loss using procedure code 92326 with one of the diagnosis codes above.

If disposable contact lenses are deemed medically necessary and are prior-authorized, procedure code V2599 must be used to bill for their reimbursement.

40.2.1.4.1 Contact Fitting for Corneal Bandage Lens

The fitting of contact lenses for corneal bandages may be reimbursed using procedure codes 92071 and 92072.

Procedure code 92071 may be reimbursed for one service per day, each eye, any provider and must be billed with modifier LT or RT. If both eyes are billed for the same date of service, one procedure may be reimbursed at the full rate and the second procedure may be reimbursed at half rate.

Procedure code 92072 may be reimbursed for one service per day when billed by the same provider when one or both eyes are fitted for keratoconus lenses.

Note: *Follow-up visits should be billed separately using the most appropriate office visit code.*

40.2.1.5 Eye Wear

The CSHCN Services Program will consider one form of eyewear for reimbursement per calendar year.

If a client wants frames or lenses that exceed the benefit limitations, the client must pay the difference between the amount allowed by the CSHCN Services Program and the actual cost. CSHCN Services Program clients or their parents or guardians must acknowledge that their choice exceeds the program requirements by signing the CSHCN Services Program Vision Care Eyeglass Client Certification Form.

Refer to: Vision Care Eyeglass Client Certificate Form (English) on the TMHP website at www.tmhp.com.

Refer to: Vision Care Eyeglass Client Certificate Form (Spanish) on the TMHP website at www.tmhp.com.

Providers must maintain a copy of this signed form in the client's medical record. The provider may withhold the noncovered eyewear until the client pays the difference. If the client fails to pay for the noncovered items within three months, the provider may return any reusable items to stock. Any payment made by the CSHCN Services Program must be refunded to the CSHCN Services Program.

More than one pair of eyeglasses may be authorized if there is a change in lens power that is generally equal to or greater than 0.50 diopters in either eye (e.g., progressive myopia, cataract development).

Providers may be reimbursed for custom-made eyewear based on the services that were performed and the materials that were used until the time the provider received a notice of cancellation for the eyewear (because the client has died or because the prescription changed before the eyewear was completed and delivered). This applies only to custom items. Items not made to order for a specific client will be denied.

One pair of contact lenses and one contact lens prescription and fitting may be covered in a calendar year for a payable diagnosis listed in the table above in Section 40.2.1.4, "Contact Lenses" in this chapter. Additional contact lenses and contact lens prescriptions and fittings within the same calendar year may be prior authorized with proof of medical necessity.

Contact lenses may require more frequent replacement than one new pair per calendar year, depending on the style and the prescribed use. More frequent replacement must be medically necessary and prior authorization must be obtained.

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The repair of lost or destroyed eyeglass frames, eyeglass lenses, or contact lenses outside of their normal replacement schedule will be allowed only if modifier RB is submitted with the appropriate procedure codes.

40.2.1.6 Services Requiring Authorization

40.2.1.6.1 Contact Lenses, Prescriptions, and Fittings

Authorization is required for medically necessary contact lenses and their prescriptions and fittings for diagnoses that are not listed in the diagnosis table above in Section 40.2.1.4, "Contact Lenses" in this chapter. Requests for authorization must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- For an established patient, current and new prescriptions that show a change of 0.5d or more in the sphere, cylinder, or prism measurements from a previous exam
- For a new patient, the new prescription including prescriptive measurements
- Which eyes are being treated: left, right, or both
- The specific procedure codes for which the authorization is being requested
- The medical necessity of contact lenses for the correction of the client's vision or for the treatment of the client's medical condition, and why eyeglasses are inappropriate or contraindicated in this case

40.2.1.6.2 Scleral Lenses and Liquid Bandages

Authorization is required for scleral lenses (procedure codes V2530 and V2531) and scleral lenses used as liquid bandage devices (procedure code S0515). Providers must submit the CSHCN Services Program Authorization and Prior Authorization Request form. Claims must be submitted with documentation of all of the following:

- The client has a condition that requires a scleral lens or a liquid bandage and is refractive to conservative treatment.
- The client has a condition that indicates a severe ocular surface disease, including, but not limited to, the following conditions:
  - Corneal ectasia such as keratoconus, pellucid marginal degeneration, keratoglobus (The use of scleral lenses does not achieve precise vision correction for high-order aberrations related to these diagnoses.)
  - Post keratoplasty astigmatism (Scleral lenses generally provide excellent visual acuity for the treatment of this condition and should be considered in lieu of wedge resections, relaxing incisions, and laser ablations.)
  - Terrien's marginal degeneration
  - Corneal surface irregularities that are due to ocular surface disease, anterior corneal dystrophies, scars, and other causes
  - Aphakia, high myopia or astigmatism
  - Corneal stem cell deficiencies that are a result of Stevens-Johnson syndrome and toxic epidermal necrosis (TEN), chemical and thermal injuries, ocular pemphigoid, aniridia, and other causes
  - Keratitis sicca that is a result of disorders of the lacrimal gland such as Sjogren's syndrome, graft vs. host disease, irradiation, surgery, and meibomian gland deficiency

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- Neurotrophic corneas resulting from herpes simplex or zoster keratitis, congenital corneal anesthesia (dysautonomia), diabetes, acoustic neuroma surgery, trigeminal ganglionectomy, trigeminal rhyzotomy, and other causes
- Persistent noninfectious corneal ulcers and epithelial defects that are associated with stem cell-deficient and neurotrophic corneas

40.2.1.7 Services Not Requiring Authorization

Authorization is not required for the following:

- One annual vision exam with refraction
- One medically necessary pair of prescription eyewear per calendar year
- One medically necessary pair of contact lenses per calendar year
- Eye exams and eye treatments for medical reasons (Medical eye exams and treatments may also include special vision services and ocular viewing and diagnostic procedures.)

Refer to: Section 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

40.2.1.8 Services Requiring Prior Authorization

A separate prior authorization request must be submitted for all contact lens replacements and for additional prescriptions and fittings of contact lenses within the calendar year. Requests must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- Which eyes are being treated: left, right, or both
- The procedure codes for which the prior authorization is being requested
- The medical necessity of either the replacement of the contact lenses or of an additional contact lens prescription and fitting within the calendar year

If a pattern of contact lens replacement is requested, the medical necessity of the pattern of replacement (e.g., monthly, every three months, or any other frequency) for the correction of a client's vision or for the treatment of a client's medical condition must be established. If the request for replacement is because of a change in prescription during the calendar year, the provider must include current and new prescriptions that show:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

Note: *A cylinder power of 0.12-0.37 diopters with a change in axis does not warrant replacement glasses.*

Providers must submit an invoice that shows the manufacturer's suggested retail price (MSRP) of the prescribed contact lenses with the prior authorization request.

Procedure code 76999 requires prior authorization. The provider must submit the following documentation with their request:

- The client's diagnosis

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- A clear, concise description of the ophthalmic ultrasound being performed
- A CPT or HCPCS procedure code which is comparable to the ophthalmic ultrasound being requested
- The physician's intended fee for this procedure
- Reason for recommending this particular procedure

Note: *Services and procedures that are investigational or experimental are not a benefit of the CSHCN Services Program.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

40.2.1.9 Eye Prostheses

Eye prostheses may be authorized when prescribed by the treating physician and when there is documentation of medical necessity and appropriateness.

There are no specific time limitations on replacement of eye prostheses. A child's eye socket may change size at variable times because of differences in bone growth rate and soft tissue change.

40.2.2 Eye and Vision Examinations

Vision services that are medically necessary for the treatment of a client include, but are not limited to, the following:

- Eye examinations and the treatment of the eye for medical reasons (i.e., aphakia diagnoses, diseases of the eye, or as a result of eye surgery or an injury to the eye). Eye examinations that are performed for medical reasons may be reimbursed as medically necessary.
- One vision examination with refraction per calendar year to obtain a prescription for eyewear for disorders of refraction and accommodation. More frequent vision exams may be reimbursed if they are recommended by a school nurse, teacher, or parent.
- One pair of nonprosthetic eyewear per calendar year.

A client who experiences vision-related difficulty with activities of daily living (ADLs) or with employment may be referred to HHSC DBS for evaluation and appropriate resources.

Special vision services, ocular viewing, and diagnostic testing include, but are not limited to, the following:

- Examination and evaluation with general anesthesia
- Ophthalmic ultrasound
- Corneal topography
- Sensorimotor examination
- Orthoptic training
- Ophthalmoscopy

40.2.2.1 Vision Examinations with Refraction

Vision examinations with refraction to obtain a prescription for eyewear (procedure code S0620 or S0621) may be reimbursed once per calendar year when billed with diagnosis codes Z0100 or Z0101.

Procedure codes S0620 and S0621 will deny if billed on the same date of service as procedure code 92020, 92273, and 92274.

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40.2.2.2 Medical Eye Examinations

Medical eye examinations performed for medical reasons may be reimbursed to providers using procedure codes 92002, 92004, 92012, 92014, and 92015. These examinations may be reimbursed as medically necessary with a valid diagnosis code that describes the medical reason for the eye examination.

A new patient is one who has not received any professional services within the past three years from the provider or another provider of the same specialty who belongs to the same group practice. Providers must use procedure codes 92002, 92004, or S0620 to bill for new patient ophthalmological eye exams provided in the office, or in an outpatient or other ambulatory facility.

An established patient is one who has received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Providers must use procedure codes 92012, 92014, or S0621 to bill for established patient ophthalmological eye exams that were provided in the office, or in an outpatient or other ambulatory facility.

Routine vision examinations, with refraction (procedure codes S0620 and S0621) will be denied as part of another service if they are billed with the same date of service as an ophthalmological medical exam (procedure codes 92002, 92004, 92012, and 92014).

A refractive state (procedure code 92015) will be denied as part of another service when billed with the same date of service by the same provider as a routine vision examination, with refraction (procedure codes S0620 or S0621).

A refractive state (procedure code 92015) may be reimbursed in addition to procedure codes 92002, 92004, 92012, and 92014.

40.2.2.3 Services Requiring Authorization

Authorization is required if a school nurse, teacher, or parent recommends an additional eye examination with refraction within a calendar year. If a new pair of eyeglasses is required as a result of the exam, an authorization is required. Requests for either authorization must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- The new prescription that shows at least one of the following:
  - A change of 0.50 diopters or more in any corresponding meridian
  - A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters
  - A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters
  - A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters
  - A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.
- The specific procedure codes for which the authorization is being requested

Note: *A cylinder power of 0.12-0.37 diopters with a change in axis does not warrant replacement glasses.*

40.2.3 Special Vision Services

40.2.3.1 Ophthalmological Examination and Evaluation with General Anesthesia

Opthalmological examination and evaluation with general anesthesia (procedure codes 92018 and 92019) may be reimbursed to ophthalmologists if a client has significant injury or cannot otherwise tolerate the procedure while conscious. Opthalmological examination and evaluation with general anesthesia is limited to one service per day, any provider.

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40.2.3.2 Ophthalmic Ultrasound

Ophthalmic ultrasound may be reimbursed to providers using the following procedure codes:

Procedure Codes								
76510	76511	76512	76513	76514	76516	76519	76529	76999

Ophthalmic ultrasounds may be reimbursed on the same date of service by the same provider as an eye examination visit or consultation.

Ophthalmic ultrasounds professional components may be reimbursed for services rendered in the office, outpatient, and inpatient hospital settings. The technical component of ophthalmic ultrasounds may be reimbursed for services rendered in the office setting.

Procedure codes 76514, 76516, and 76519 are limited to one service per day, any provider. Procedure codes 76510, 76511, 76512, 76513, 76514, 76516, and 76519 are limited to two services per calendar year, any provider.

Procedure code 76519 may be reimbursed as follows:

- The professional component must be billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed once when one or both eyes are performed on the same date of service by any provider.
- The total component may be reimbursed with an additional professional service when both eyes are performed on the same date of service by any provider.

40.2.3.3 Corneal Topography

Corneal topography (procedure code 92025) may be reimbursed to providers and is limited to one service per day, and two services per calendar year by any provider. Corneal topography is limited to the following diagnosis codes:

Diagnosis Codes							
H10211	H10212	H10213	H10811	H10812	H10813	H10821	H10822
H10823	H10829	H11001	H11002	H11003	H11011	H11012	H11013
H11021	H11022	H11023	H11031	H11032	H11033	H11041	H11042
H11043	H11051	H11052	H11053	H11061	H11062	H11063	H1189
H16001	H16002	H16003	H16011	H16012	H16013	H16021	H16022
H16023	H16031	H16032	H16033	H16041	H16042	H16043	H16051
H16052	H16053	H16061	H16062	H16063	H16071	H16072	H16073
H16101	H16102	H16103	H16111	H16112	H16113	H16121	H16122
H16123	H16131	H16132	H16133	H16141	H16142	H16143	H16201
H16202	H16203	H16211	H16212	H16213	H16221	H16222	H16223
H16231	H16232	H16233	H16251	H16252	H16253	H16261	H16262
H16263	H16291	H16292	H16293	H16301	H16302	H16303	H16311
H16312	H16313	H16321	H16322	H16323	H16331	H16332	H16333
H16391	H16392	H16393	H16401	H16402	H16403	H16411	H16412
H16413	H16421	H16422	H16423	H16431	H16432	H16433	H16441
H16442	H16443	H168	H169	H1701	H1702	H1703	H1711
H1712	H1713	H17811	H17812	H17813	H17821	H17822	H17823

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Diagnosis Codes							
H1789	H179	H1811	H1812	H1813	H1820	H18221	H18222
H18223	H18231	H18232	H18233	H1840	H18451	H18452	H18453
H18461	H18462	H18463	H1849	H18501	H18502	H18503	H18509
H18511	H18512	H18513	H18519	H18521	H18522	H18523	H18529
H18531	H18532	H18533	H18539	H18541	H18542	H18543	H18549
H18551	H18552	H18553	H18559	H18591	H18592	H18593	H18599
H18601	H18602	H18603	H18611	H18612	H18613	H18621	H18622
H18623	H1870	H18711	H18712	H18713	H18721	H18722	H18723
H18731	H18732	H18733	H18791	H18792	H18793	H18831	H18832
H18833	H52201	H52202	H52203	H52211	H52212	H52213	L511
L512	L513	Q134	S0521XA	S0521XD	S0521XS	S0522XA	S0522XD
S0522XS	S0531XA	S0531XD	S0531XS	S0532XA	S0532XD	S0532XS	T2611XA
T2611XD	T2611XS	T2612XA	T2612XD	T2612XS	T2661XA	T2661XD	T2661XS
T2662XA	T2662XD	T2662XS	T85310A	T85310D	T85310S	T85311A	T85311D
T85311S	T85318A	T85318D	T85318S	T85320A	T85320D	T85320S	T85321A
T85321D	T85321S	T85328A	T85328D	T85328S	T85390A	T85390D	T85390S
T85391A	T85391D	T85391S	T85398A	T85398D	T85398S	Z48810	Z947
Z9841	Z9842	Z9849	Z9883				

Corneal topography may be reimbursed on the same date of service by the same provider as a medical eye exam or simple refraction (procedure codes 92002, 92004, 92012, 92014, or 92015).

40.2.3.4 Sensorimotor Examination

Sensorimotor examinations (procedure code 92060) may be reimbursed in addition to a medical eye examination or simple refraction.

Sensorimotor examination is limited to once per day and two per calendar year by any provider.

40.2.3.5 Orthoptic Training

Orthoptic training (procedure codes 92065 and 92066) may be reimbursed in addition to a medical eye examination visit.

Orthoptic training is limited to once per day and 36 per year by any provider.

40.2.3.6 Opthalmoscopy

Opthalmoscopy may be reimbursed to providers using the following procedure codes:

Procedure Codes							
92201	92202	92230	92235	92240	92242	92250	92260

Opthalmoscopy, fluorescein angioscopy, indocyanin-green angiography, and fluorescein angiography (procedure codes 92230, 92235, 92240, and 92242) may be reimbursed for a quantity of two if both the left and right eyes are evaluated. Modifiers LT and RT must be included on the claim to identify the eye on which the service was performed.

Ophthalmoscopy, fluorescein angioscopy, indocyanin-green angiography, and fluorescein angiography (procedure codes 92230, 92235, 92240, and 92242) are limited to one service per eye, per day and two services per eye, per calendar year by any provider.

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Opthalmoscopy, extended (procedure codes 92201 and 92202) are limited to one service per day and two services per calendar year by any provider.

Fundus photography (procedure code 92250) and opthalmodynamometry (procedure code 92260) are limited to one service per day and two services per calendar year by any provider.

40.2.3.7 Ocular Viewing and Diagnostic Testing Procedures

Ophthalmologists and optometrists may submit the following procedure codes for the reimbursement of ocular viewing and diagnostic testing:

Ocular Viewing and Diagnostic Testing Procedure Codes									
92020	92081	92082	92083	92100	92132	92133	92134	92136	92137
92227	92228	92229	92265	92270	92273	92274	92285	92286	92287

Gonioscopy (procedure code 92020) is limited to two services per calendar year by any provider.

Visual field examinations (procedure codes 92081, 92082, and 92083), serial tonometry (procedure code 92100), and computerized ophthalmic diagnostic imaging (procedure codes 92132, 92133, 92134, and 92137) are limited to one service per day and two services per calendar year by any provider.

Ophthalmic biometry (procedure code 92136) is limited to two services per eye, per calendar year by any provider.

Procedure code 92136 may be reimbursed as follows:

- The professional component must be billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed when one or both eyes are performed on the same date of service by any provider.
- The total component may be reimbursed with an additional professional service when both eyes are performed on the same date of service by any provider.

Procedure codes 92227. 92228, and 92229 are limited to two services per calendar year by any provider.

Procedure codes 92265, 92270, 92273, 92274, 92285, 92286, and 92287 are limited to one service per day and two services per calendar year when billed by any provider.

40.3 Claims Information

The repair or replacement of lost or destroyed eyeglass frames, eyeglass lenses, or contact lenses outside of their normal replacement schedule will be allowed only if the RB modifier is submitted with the appropriate procedure codes.

Eyewear for a diagnosis of aphakia must be billed with modifier VP.

The MSRP must be submitted for the consideration of the purchase of high-powered and aphakic lenses with the appropriate procedure codes.

Opticians enrolled as a facility must submit claims with their NPI in both the billing provider field (Block 33 on a paper claim or the electronic equivalent) and in the performing provider field (Block 24J on a paper claim or the electronic equivalent.)

Vision services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

40.4 Reimbursement

Contact lenses, frames, and eyeglass lenses, except for high-power and aphakic lenses, may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. High-powered lenses and lenses for aphakia are manually priced. Manually-priced items are reimbursed at the retail price minus a discount as determined by the CSHCN Services Program rule. An invoice that shows the actual MSRP must be filed with every claim of this type.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

40.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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