Vision Services

Policy

Mass General Brigham Health Plan reimburses contracted ophthalmologists and optometrists for routine and medically necessary vision services. Mass General Brigham Health Plan does not reimburse separately for refraction, except when performed in relation to post-cataract surgery and keratoconus.

Policy Limitations

This policy applies to all places of service, including but not limited to; outpatient, inpatient, and emergency room services in accordance with the National POS code set.

Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any. Mass General Brigham Health Plan suggests that providers do not bill the member for services prior to adjudication of claim(s) in order for the accurate member responsibility to be calculated. Any member responsibility for copayments, coinsurance, and/or deductible will be reflected on the Explanation of Payment (EOP) and the member's Explanation of Benefits (EOB).

Authorization, Notification and Referral

Service	Requirement
Routine Eye Care	• Frequency limits apply based on plan type. • Commonwealth Care members have their routine vision care benefit managed by Spectera. • PCP Referral **and** prior authorization by Mass General Brigham Health Plan is required for non-contracted

Service	Requirement
Non-Routine Eye Care	• Referral is required for contracted providers. • Prior authorization from Mass General Brigham Health Planis are required for non-contracted providers. • Prior authorization is required for eye related cosmetic surgery.

Service Limitations

Mass General Brigham Health Plan reimburses eligible and qualified providers according to the requirements and limitations set forth in this policy and where benefit limits apply.

Service Code	Description	Comments
92002-92014	Evaluation & Management services	• Submit with the most specific ICD-10 code(s) available • Claims should not be submitted with ICD-10 *H57.9*
92015	Determination of refractive state	• Reimbursed separately only when performed post-cataract surgery and treatment of keratoconus • Must be submitted with one of the following ICD-10 diagnosis codes: *Z98.49, H25.xx, H26.xx, H28.xx, H18.609, H18.619, H18.629*
92072	Fitting of contact lens for management of keratoconus, initial fitting	• Must be submitted with one of the following ICD-10 codes; *H18.609, H18.619, H18.629*

Service Code	Description	Comments
92071	Fitting of contact lens for treatment of ocular surface disease	Must be submitted with one of the following ICD-10 codes; *Z98.49, H25.xx, H26.xx, H28.xx, H18.609, H18.619, H18.629*

Membership	Requirement
Commercial and Medicare Advantage	• Eyeglasses or contact lenses are only covered through Mass General Brigham Health Plan when related to cataract or keratoconus. • Prior authorization is **required** from Mass General Brigham Health Plan. • Benefit limits apply.
Commonwealth Care	• Commonwealth Care members have their routine vision care benefit managed by Spectera. Please contact Spectera for requirements.
MassHealth	• MassHealth members have coverage for eyewear directly through MassHealth. Please contact MassHealth for requirements.

Mass General Brigham Health Plan Does Not Reimburse

- CPT 92015, *Determination of refractive state*, will not be reimbursed separately when billed for services not related to post-cataract extraction or the treatment of keratoconus.
- Eyewear (frames or contact lenses) when not directly related to post-cataract surgery or keratoconus which have not been prior-authorized by Mass General Brigham Health Plan.
- Services billed using an 'unassigned' place of service code.
- Consultation services as defined by CPT code ranges 99242-99245 and 99252-99255
- Designer/luxury lenses and frames; such as Crystalens
- CPT code 99177- deny as not reimbursable when billed with Preventive Service
- Services and/or procedures which are considered to be experimental or investigational in
- nature.

Billing Limitations

- All claims must be filed within 90 days of the date of service.
- Claims should not be billed with the following ICD-10 as the primary diagnosis;
    - **H57.9** Unspecified disorder of the eye and adnexa
    - **H57.8** Other specified disorders of eye and adnexa
    - **H53.8** Other visual disturbances
    - **H53.9** Unspecified visual disturbance

Definitions

Optometrist: Eye health care professionals who are state-licensed to diagnose and treat diseases and disorders of the eye and visual system. Under Massachusetts General Law optometrists are allowed to diagnose, manage and treat eye conditions and eye diseases. This includes evaluating the eye with dilated eye exams, prescribing corrective lenses, removing foreign objects from the eye and writing prescriptions for therapeutic pharmaceutical agents (TPAs).

Ophthalmologist: A medical doctor specializing in the diagnosis, management and treatment of diseases/disorders of the eye.

Refraction: The determination of visual acuity by use of a refractor, a device that contains a range of lens powers that can be quickly changed, allowing the patient to compare various combinations when viewing an eye chart.

Routine Eye Examination: An examination conducted to evaluate the health and status of the eyes and vision acuity. Routine eye exams are not typically conducted in the presence of a medical diagnosis, nor require the conclusion of a medical diagnosis.

References

CMS MLN Fact Sheet, Medicare Vision Services, MLN907165
Current AMA CPT Professional Edition Manual
MassHealth Physician Manual
Mass General Brigham Health Plan Evaluation and Management Services Guideline
Mass General Brigham Health Plan Medical Policy, Therapeutic & Scleral Lens Clinical Coverage Criteria
M.G.L. Chapter 112, Section 66, Subsections 66A and 66B

Publication History

Topic: Vision Services (Eye Examinations and Refractions)	Owner: Network Management

May 1, 2013	*Original documentation*
October 1, 2013	*Requirement of referral for routine vision services removed & Member Cost Sharing language updated.*
June 20, 2014	*Updated refraction coverage language*
September 2, 2015	*Added ICD-10 codes only*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
January 1, 2023	*Document rebrand; updated references*
January 1, 2024	*Annual review, updated references*
January 1, 2025	*Annual review, no policy change*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.

1 CPT Code list is not all inclusive of all services