Vision Services Payment Policy

Policy

The Plan entered into an agreement with EyeMed Vision Care (EyeMed) to manage the Plan's vision and eyewear benefits effective July 1, 2012.

Vision center and/or optometry services:
In order to continue to service Plan members after July 1, 2012, providers need to be participating in the EyeMed Vision Care network. Call the EyeMed Provider Relations line at 1-888-581-3648 to initiate discussions with them regarding network participation.

Ophthalmology services:
In order to continue to provide routine vision care to Plan members, ophthalmologists must be credentialed through EyeMed. All routine vision care claims must be submitted to EyeMed. All medical claims should continue to be submitted to the Plan.

Reimbursement

Diagnostic eye exams:
The Plan will reimburse ophthalmologists for diagnostic eye exams when billed with the appropriate CPT codes, i.e., 92002-92014, and a non-routine diagnosis code.

Refraction:
For members enrolled through MassHealth and for members enrolled in the Plan's NaviCare® program, the Plan will reimburse refraction code 92015 regardless of diagnosis.

For all other Plan members, the Plan will reimburse ophthalmologists for refraction following cataract surgery only. Providers should submit a claim for refraction (92015) utilizing an appropriate ICD-10-CM code(s), such as Z98.41 (Cataract extraction status, right eye) or Z98.42 (Cataract extraction status, left eye) to the Plan.

Fittings for contact lenses (92071-92072) are not reimbursed.

Note: all Optometry claims (routine and medical) should be submitted to EyeMed. All medical Ophthalmology claims should be sent to Fallon directly and Ophthalmology claims for routine services only should be submitted to EyeMed.

Referral/notification/prior authorization requirements

Most Plan members may self-refer for routine eye exams. PCP referral is required for diagnostic eye exams, unless otherwise specified in the member's Evidence of Coverage.

Fallon Health Weinberg and NaviCare models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

All vision center and/or optometry services:
Providers need to be participating in the EyeMed Vision Care network, and all claims must be submitted directly to EyeMed for dates of service on or after July 1, 2012.

Ophthalmology services:

In order to continue to provide routine vision care to Plan members, ophthalmologists must be credentialed through EyeMed. All routine vision care claims must be submitted to EyeMed. All medical claims should continue to be submitted to the Plan.

Claims with the following diagnosis codes are considered routine and must be submitted to EyeMed:

ICD-10 Diagnosis code	Description
H52.00	Hypermetropia, unspecified eye
H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.10	Myopia, unspecified eye
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.209	Unspecified astigmatism, unspecified eye
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.219	Irregular astigmatism, unspecified eye
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.229	Regular astigmatism, unspecified eye
H52.31	Anisometropia
H52.32	Aniseikonia
H52.4	Presbyopia
H52.511	Internal ophthalmoplegia (complete) (total), right eye
H52.512	Internal ophthalmoplegia (complete) (total), left eye
H52.513	Internal ophthalmoplegia (complete) (total), bilateral
H52.519	Internal ophthalmoplegia (complete) (total), unspecified eye
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.529	Paresis of accommodation, unspecified eye
H52.531	Spasm of accommodation, right eye
H52.532	Spasm of accommodation, left eye
H52.533	Spasm of accommodation, bilateral
H52.539	Spasm of accommodation, unspecified eye
H52.6	Other disorders of refraction
H52.7	Unspecified disorder of refraction
H53.71	Glare sensitivity
H53.72	Impaired contrast sensitivity

ICD-10 Diagnosis code	Description
H53.8	Other visual disturbances
H53.9	Unspecified visual disturbance
Z01.00	Encounter for examination of eyes and vision without abnormal findings
Z01.01	Encounter for examination of eyes and vision with abnormal findings

Providers can submit claims for routine services online through EyeMed's provider website: eyemedvisioncare.com. Call the EyeMed Provider Relations line at 1-888-581-3648 for assistance.

Policy history

Origination date: 11/09/2005

Previous revision date(s): 05/10/2006, 05/09/2007
07/01/2012 - renamed to Vision Services Payment Policy. Updated content to reflect FCHP's relationship with EyeMed Vision Care effective July 1, 2012.
03/01/2013 - Updated list of routine diagnoses.
11/01/2015 - Moved to new Plan template and updated reimbursement and billing/coding guidelines sections with ICD-10 codes.
01/01/2017 - Annual review.

Connection date & details: May 2017 – Updated refraction reimbursement language.
July 2018 – Annual review, no updates.
July 2019 – Updated the reimbursement section.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.