VISION CARE
Procedure Codes

eMedNY New York State Medicaid Provider Procedure Code Manual

New York State Medicaid
Office of Health Insurance
Department of Health

CONTACTS and LINKS:

eMedNY URL
https://www.emedny.org/

ePACES Reference Guide
https://www.emedny.org/selfhelp/ePACES/PDFS/5010_ePACES_Professional_Real_Time_Claim_Reference_Guide.pdf

eMedNY Contact Information
(800) 343-9000
eMedNY: Billing Questions, Remittance Clarification, Request for Claim Forms, ePACES Enrollment, Electronic Claim Submission Support (eXchange, FTP), Provider Enrollment, Requests for paper prior approval forms

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2 GENERAL INFORMATION AND INSTRUCTIONS

A. Fee Schedule: The fees listed in the Vision Care Fee Schedule, available at: http://www.emedny.org/ProviderManuals/VisionCare/, apply to self- employed and salaried optometrists, dispensing opticians and retail optical establishments and **are the maximum reimbursable Medicaid fees**. **Ophthalmologists cannot bill using this Manual.**

B. Multiple Calls: If an individual patient is seen on more than one occasion during a single day, the fee for each visit may be allowed.

C. Charges for Diagnostic Procedures: Charges for special diagnostic procedures which are not considered to be a routine part of an attending optometrist's examination or visit (e.g., gonioscopy, extended ophthalmoscopy) are reimbursable in addition to the usual optometrist's visit fee.

D. Referral: A referral is the transfer of the total or specific care of a patient from one practitioner to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in LEVELS of E/M SERVICE.

E. Consultation: Consultation is to be distinguished from referral. REFERRAL is the transfer of the patient from one practitioner to another for definitive treatment. CONSULTATION is advice and opinion from an optometry specialist called in by the attending practitioner in regard to the further management of the patient by the attending practitioner.

Consultation fees are applicable only when examinations are provided by an optometry specialist within the scope of his specialty upon request of the attending practitioner who is treating the medical problem for which consultation is required. The attending practitioner must certify that he requested such consultation and that it was incident and necessary to his further care of the patient.

When the consultant optometrist assumes responsibility for a portion of patient management, he will be rendering concurrent care (use appropriate level of Evaluation and Management codes). If he has had the case transferred or referred to him, he should then use the appropriate codes for services rendered (e.g., visits, procedures) on and subsequent to the date of transfer.

F. **By Report**: A service that is rarely provided, unusual, variable, or new may require a special report in determining clinical appropriateness of the service, indicated by a "**BR**" in the Fee Schedule. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate), diagnostic and therapeutic procedures (including supplementary procedures, if appropriate), concurrent problems, and follow-up care.

When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (e.g., procedure description, itemized invoices, etc.) should accompany all claims submitted.

Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

G. **Payment in Full**: Fees paid in accordance with the allowances in the New York State Vision Care Fee Schedule shall be considered full payment for services rendered. No additional charge shall be made by a provider.

H. **Separate Procedure**: Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Separate Procedure" is applicable.

I. **Prior Approval**: Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

J. **Low Vision Services**: Low vision examination, low vision aids and fitting of low vision aids are reimbursable to self-employed optometrists specifically certified by the New York State Optometric Association to perform low vision examinations. (Code W0021 has been deleted. To report low vision examination, use codes 92002-92014.)

3 MMIS MODIFIERS

Under certain circumstances, the procedure code identifying a specific procedure or service must be expanded by two additional characters to further define or explain the nature of the procedure. The circumstances under which such further description is required are detailed below along with the appropriate modifiers to be added to the basic code when the particular circumstance applies.

LT Left Side: Used to identify procedures performed on the left side of the body)
Add modifier –LT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.

RB Replacement: Replacement of lost, destroyed or broken eyeglasses may be reported by adding the modifier –RB to the eyeglass material codes and the fitting code.

RT Right Side: Used to identify procedures performed on the right side of the body modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.)

4 EVALUATION AND MANAGEMENT SERVICES DEFINITIONS

1. CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES: The Federal Health Care Finance Administration has mandated that all state Medicaid programs utilize the Evaluation and Management coding as published in the American Medical Association's Physicians' Current Procedural Terminology for services covered by the program.

2. LEVELS OF E/M SERVICES: Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. The Evaluation and Management guidelines in the CPT book should be referenced when selecting the level of E/M codes.

5 SERVICES SECTION

5.1 GENERAL INFORMATION AND RULES

1. Prior Approval: Payment for those listed procedures in the Fee Schedule where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

2. Complete optometric eye examination: Codes 92002-92014 are for complete optometric eye examinations minimally comprised of a case history, an internal and external eye examination, objective and subjective determination of refractive state, binocular coordination testing, gross visual field testing and tonometry for recipients age 35 and over or others where indicated. Routine ophthalmoscopy and confrontational testing for visual field assessment are part of a complete optometric eye examination. The fee for the comprehensive level of complete optometric eye examination requires the use of a diagnostic pharmaceutical agent as an integral part of the service and includes reimbursement for the postcycloplegic encounter.

6 EVALUATION AND MANAGEMENT CODES

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

6.1 OFFICE SERVICES

The following codes are used to report evaluation and management services provided in the optometrist's office.

6.1.1 NEW PATIENT

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and low level of medical decision making. When using time for code selection, 30 minutes must be met or exceeded.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and moderate level of medical decision making. When using time for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and high level of medical decision making. When using time for code selection, 60 minutes must be met or exceeded.

6.1.2 ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

99211 Office or other outpatient visit for the evaluation and management of an established

patient, that may not require the presence of a physician or other qualified health care professional.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

6.2 CONSULTATIONS (BY SPECIALISTS)

A consultation is a type of service provided by an optometrist whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another practitioner or other appropriate source.

An optometry consultant may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending practitioner and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting practitioner.

A "consultation" initiated by a patient and/or family is not reported using the consultation codes, but may be reported using the codes for visits, as appropriate.

Any specifically identifiable procedure (i.e., identified with a specific procedure code) performed on or subsequent to the date of the initial consultation should be reported separately.

On and subsequent to the date a consultant assumes responsibility for the management of a portion or all of the patient's condition(s); the consultation codes should not be used.

6.2.1 OFFICE CONSULTATION - New or Established Patient

The following codes are used to report consultations provided in the optometrist's office.

Follow-up visits in the consultant's office that are initiated by the optometry consultant are

reported using office visit codes for established patients (99211-99212). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending practitioner and documented in the medical record, the office consultation codes may be used again.

99242 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99243 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99244 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

6.2.2 PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN OFFICE VISIT OR OTHER OUTPATIENT SERVICES

99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)

7 OPHTHALMOLOGICAL DIAGNOSTIC AND TREATMENT SERVICES

7.1.1 GENERAL OPHTHALMOLOGICAL SERVICES

The designation of new or established patient does not preclude the use of a specific level of service. For Evaluation and Management services see 99202 et seq.

7.1.1.1 NEW PATIENT

A new patient is one who has not received any professional services from the provider within the past three years.

92002 Ophthalmological services: (complete eye examination) medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient (with/without refraction)

92004 comprehensive, new patient (with/without refraction)

7.1.1.2 ESTABLISHED PATIENT

An established patient is one who has received professional services from the provider within the

past three years and whose medical and administrative records are available to the provider.

92012 Ophthalmological services: (complete eye examination) medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient (with/without refraction)
92014 comprehensive, established patient (with/without refraction)

7.1.2 SPECIAL OPHTHALMOLOGICAL SERVICES

92020 Gonioscopy (separate procedure)
92060 Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92065 Orthoptic training; performed by a physician or other qualified health care professional
92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082 intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semi quantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083 extended examination, (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G 1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100 Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)
92132 Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral
92133 Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment with interpretation and report, unilateral or bilateral; optic nerve
92134 retina

7.1.2.1 OPHTHALMOSCOPY

92201 Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
92202 with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
92250 Fundus photography with interpretation and report (one or both eyes) (LT, RT modifiers valid)

7.1.2.2 OTHER SPECIALIZED SERVICES

92270 Electro-oculography with interpretation and report
92273 Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG,

Ganzfeld (ERG)
92274 multifocal (mfERG)

7.1.3 CONTACT LENS SERVICES

92310 Prescription of optical and physical characteristics of and fitting of contact lens, (includes materials) with medical supervision of adaptation (for ocular pathology); corneal lens, both eyes, except for aphakia
(Reimbursement for one eye is limited to $150.00)
(Reimbursement for both eyes requires BR)
92311 corneal lens for aphakia, one eye (LT or RT modifier valid)
92312 corneal lens for aphakia, both eyes
92313 corneoscleral lens (one or both eyes) (LT, RT modifiers valid)
92326 Replacement of contact lens (one or both eyes) (LT, RT modifiers valid)

7.1.4 PROSTHETIC EYE

V2623 Prosthetic eye, plastic, custom (Includes fitting and supply of ocular prosthesis and clinical supervision of adaption)
V2624 Polishing/resurfacing of ocular prosthesis
V2625 Enlargement of ocular prosthesis
V2626 Reduction of ocular prosthesis
V2627 Scleral cover shell
(When prescribed as an artificial support to a shrunken and sightless eye or as barrier in treatment of severe dry eye)
(Includes supply of shell, fitting and clinical supervision of adaption)

7.1.5 SPECTACLE SERVICES (INCLUDING PROSTHESIS FOR APHAKIA)

92340 Fitting of spectacles, except for aphakia; monofocal
92341 bifocal
92342 multifocal, other than bifocal
92352 Fitting of spectacle prosthesis for aphakia; monofocal
92353 multifocal
92354 Fitting of spectacle mounted low vision aid; single element system
(Includes fitting of low vision aid and visual rehabilitation),
(Reimbursable to self-employed optometrists certified to perform low vision examinations)
92355 telescopic or other compound lens system
92370 Repair and refitting spectacles; except for aphakia
92371 spectacle prosthesis for aphakia

7.1.6 OTHER SERVICES

76514 Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
95930 Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

8 PROCEDURE SECTION

8.1 GENERAL INFORMATION AND RULES

A. Follow-Up Days: Listed dollar values for all procedures include the procedure and the follow-up care for the period indicated in days in the column headed "FU DAYS" in the Fee Schedule. Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis.

B. Additional Services: Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis.

C. When an additional procedure(s) is carried out within the listed period of follow-up care for a previous procedure, the follow-up periods will continue concurrently to their normal terminations.

D. Multiple Procedures:
   a. When multiple or bilateral procedures, which add significant time or complexity to patient care, are performed at the same session, the total dollar value shall be the value of the primary procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified. (For reporting bilateral procedures, see modifier –50.)
   b. When an incidental procedure is performed at the same time, the fee will be that of the primary procedure only.

E. Prior Approval: Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

8.1.1 MMIS MODIFIERS

LT Left Side: Used to identify procedure performed on the left side of the body. Add modifier –LT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.)

RT Right Side: Used to identify procedures performed on the right side of the body. Add modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.)

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by the appropriate procedure code describing the first procedure. To indicate a bilateral procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum State Medical Fee Schedule amount. One claim line is to be billed. Amount billed should reflect total amount due.)

8.2 EYE AND OCULAR ADNEXA CODES

8.2.1 EXCISION

67820 Correction of trichiasis; epilation, by forceps only (LT, RT modifiers valid)

8.2.2 REPAIR

68761 Closure of the lacrimal punctum; by plug, each (LT, RT modifiers valid)

8.2.3 PROBING AND/OR RELATED PROCEDURES

68801 Dilation of lacrimal punctum, with or without irrigation
68810 Probing of nasolacrimal duct, with or without irrigation;
68840 Probing of lacrimal canaliculi, with or without irrigation (LT, RT modifiers valid)

9 MATERIALS SECTION

9.1 GENERAL INFORMATION AND RULES

A. Prior Approval: Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

B. By Report: When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (e.g., procedure description, itemized invoices, etc.) should accompany all claims submitted. When billing for materials "By Report" (BR), an itemized invoice must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

C. **Lens fees**: Lens fees listed in the Fee Schedule are "per lens" for first quality plastic or glass lenses meeting F.D.A. Regulations, finished into a frame and **include** the **first three degrees of prism per lens pair**.

D. **10DS or greater lens**: A 10DS or greater lens is reimbursable at acquisition cost documented by an itemized invoice, with the full refraction indicated on it, when such cost is greater than the listed fee.

E. **Balance lens**: For code, **V2700-Balance lens**, enter 50% of the amount for the corrective lens in the amount charged field.

F. **Modifier -RB (Replacement):** Replacement of lost, destroyed or broken eyeglasses may be reported by adding the modifier –RB to the eyeglass material codes and the fitting code.

9.1.1 FRAMES

V2020 Frames, purchases

9.1.2 SPHERE, SINGLE VISION, PER LENS;

V2100 plano to plus or minus 4.00
V2101 plus or minus 4.12 to plus or minus 7.00D
V2102 plus or minus 7.12 to plus or minus 20.00D

9.1.3 SINGLE VISOIN, GLASS, OR PLASTIC

V2103 plano to plus or minus 4.00D sphere, 0.12 to 2.00D cylinder
V2104 plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder
V2105 plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder
V2106 plano to plus or minus 4.00D sphere, over 6.00D cylinder
V2107 plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00D cylinder
V2108 plus or minus 4.25 to plus or minus 7.00 sphere, 2.12 to 4.00D cylinder
V2109 plus or minus 4.25 to plus or minus 7.00 sphere, 4.25 to 6.00D cylinder
V2110 plus or minus 4.25 to plus or minus 7.00 sphere, over 6.00D cylinder
V2111 plus or minus 7.25 to plus or minus 12.00D sphere, 0.25 to 2.25D cylinder
V2112 plus or minus 7.25 to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder
V2113 plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder
V2114 sphere over plus or minus 12.00D
V2115 Lenticular (myodisc), per lens single vision
V2118 Aniseikonic lens, single vision
V2121 Lenticular lens, per lens, single vision
V2199 Not otherwise classified, single vision lens

9.1.4 BIFOCAL, GLASS, OR PLASTIC

V2200 plano to plus or minus 4.OODS
V2201 plus or minus 4.12 to plus or minus 7.00D

V2202 plus or minus 7.12 to plus or minus 20.00D
V2203 plano to plus or minus 4.00D sphere, 0.12 to 2.00D cylinder
V2204 plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder
V2205 plano to plus or minus 4.00D sphere, 4.25 TO 6.00D cylinder
V2206 plano to plus or minus 4.00D sphere, over 6.00D cylinder
V2207 plus or minus 4.25 to plus or minus 7.00D sphere, 0.12 to 2.00D cylinder
V2208 plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder
V2209 plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder
V2210 plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder
V2211 plus or minus 7.25 to plus or minus 12.00D sphere, 0.25 to 2.25D cylinder
V2212 plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder
V2213 plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder
V2214 sphere over plus or minus 12.00D
V2215 Lenticular (myodisc), per lens, bifocal
V2218 Aniseikonic, per lens, bifocal
V2219 Bifocal seg width over 28 mm
V2220 Bifocal add over 3.25D
V2221 Lenticular lens, per lens, bifocal

9.1.5 TRIFOCAL, GLASS, OR PLASTIC

V2321 Lenticular lens, per lens, trifocal

9.1.6 POLYCARBONATE

S0580 Polycarbonate lens
(List in addition to basic code for lens)
(Ages 21 and over require medical documentation)
(The beneficiary must be essentially monocular with functional vision in only one eye or have a history of auto aggressive behavior with a history of breaking glasses. This documentation must be submitted with claims for beneficiaries 21 and over. The statement qualifying the beneficiary's vision should be from an ophthalmologist or optometrist.)

9.1.7 VARIABLE ASPHERICITY LENS, GLASS, OR PLASTIC

V2410 Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430 bifocal, full field glass or plastic, per lens
V2499 Variable sphericity lens, other type
V2700 Balance lens, per lens
(See Rule E, Reimbursement is limited to 50% of the corrective lens)
V2710 Slab off prism, glass or plastic, per lens
V2715 Prism, per lens (See Rule C)
V2718 Press-on lens, Fresnel prism
V2745 Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens (applicable with a diagnosis code of visual sensitivity due to photophobia on the order)

V2770 Occluder lens, per lens (or plastic occluder)
V2799 Vision item or service, miscellaneous (Unlisted ophthalmic service or material)

9.1.8 VISION AIDS

Reimbursable to self-employed optometrists certified to perform low vision examinations.

For each low vision aid, bill using the appropriate code and indicate the specific description with the corresponding maximum fee as listed in the Fee Schedule.

V2600 Hand held low vision aids and other non-spectacle mounted aids
Hand held telescope
Aloe-type clip on near telescope, 3.5X
Telesight +3.00 to +8.00
Microscopic Plastic Prism Spectacles
Aspheric Microscope (Plastic)
Cataract Aspheric Hand Magnifier

V2610 Single lens spectacle mounted low vision aids
Clear Image: One telescope including balance lens, correction lens and one or more reading caps
Bioptic: One telescope including balance lens, correction lens and one reading cap
Trioptic: One lens, telescope plus microscope and balance lens
Kollmorgan: One telescope including reading cap plus balance lens
Clear image: Microscope 3X to 20X, plus balance lens
Bifocal Microscope: One Microscope lens 2X to 20X including dummy lens and 2 carrier lenses plus frame and case

V2615 Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system
Clear Image: Telescopes 2.2X, two lenses plus correction lenses and one or more reading caps
Bioptic: Telescopes 2.2X or 3X, two lenses including correction lenses and one or more reading caps
Trioptic: Telescopes plus microscopes, two lenses including correction lens

10 MISCELLANEOUS

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
G0109 Diabetes outpatient self-management training services, group session (two or more), per 30 minutes
T1013 Sign language or oral interpretive services, per 15 minutes