Low Vision Aids

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This section contains general information about low vision aids and program coverage (*California Code of Regulations* [CCR], Title 22, Section 51317[f]).

Program Coverage

Optical low vision aids are covered if:

- The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point.
- The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means.
- The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient.
- The aid prescribed or provided is the least costly type that will meet the needs of the recipient.

Electronic Magnification Devices

Electronic magnification devices and devices that do not incorporate a lens for use with the eye are not Medi-Cal benefits.

Billing

Low Vision Examination

Low vision examinations must be billed with CPT® code 92499 (unlisted ophthalmological service or procedure) and a valid ICD-10-CM diagnosis code in the range of H54.0X33 to H54.3, H54.8 (blindness and low vision). Although authorization is not required prior to billing the low vision examination, justification of medical necessity as listed under “Required Information” in this section must be included with the claim for Medical Review.

The low vision examination includes the professional evaluation, fitting of the low vision aid and subsequent supervision, if appropriate, including six months of follow-up care.

Low Vision Aids

The following HCPCS codes should be used when billing low vision aids:

Code	Description
V2600	Hand held low vision aids and other non-spectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2315	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system

Note: When billing for multiple low vision aids, providers must use a separate claim line item for each aid. Therefore, the maximum quantity billed for HCPCS code V2600, V2610 or V2615 is "1."

Modifiers

HCPCS codes V2600 thru V2615 must be billed with an appropriate modifier on the claim for payment: Modifiers required for billing low vision aids include:

- NU: New equipment
- RA: Replacement of a Durable Medical Equipment item

Modifier NU is used when supplying or dispensing low vision aids to recipients with no prior history of usage of the low vision aids.

Modifier RA is used to indicate replacement of a low vision aid that has been in use for some time.

For a list of modifiers to be used as specified in policy, refer to the *Modifiers Used with Vision Care Procedure Codes* section in this manual.

Required Information

All claims for low vision examinations (CPT-code 92499) and low vision aids (HCPCS codes V2600, V2610 and V2615) require additional medical justification for reimbursement. For HCPCS codes V2600, V2610 and V2615, a valid *Treatment Authorization Request* (TAR) serves as the required medical justification. An additional report is not required.

For CPT code 92499 or HCPCS codes V2600, V2610 and V2615 without valid TARs, the following information must be included with the claim:

- Beneficiary's name and date of birth
- Spectacle prescription and best-corrected visual acuities (measured monocularly), where possible
- Visual acuities through the low vision aid. For near point use, also state working distance.
- The etiology, current status and prognosis of the visual defect
- The purpose of the prescribed low vision aid in the recipient's daily living activities
- Aid identification, including catalog device name/number, manufacturer/distributor and cost

‹‹CPT Code 92499 requires the following additional information as well:››

- Results from any additional low vision tests performed to justify a low vision exam (e.g. contrast, glare sensitivity)
- Identification of the low vision aids trialed, and which aids were prescribed. If no low vision aid was prescribed, an explanation why

Date Appliance Delivered

Welfare and Institutions Code (W&I Code) Section 14043.341 requires providers to obtain and keep a record of Medi-Cal recipients' signatures when dispensing a product or prescription or when obtaining a laboratory specimen.

Therefore, dispensing optical providers (ophthalmologists, optometrists, and dispensing opticians) who dispense a device (eye appliances) requiring a written order or prescription must maintain the following items in their files to qualify for Medi-Cal reimbursement:

- Signature of the person receiving the eye appliance
- Medi-Cal recipient's printed name and signature
- Date signed
- Prescription number or item description of the eye appliance dispensed
- Relationship of the recipient to the person receiving the prescription if the recipient is not picking up the eye appliance

Authorization

When the billed amount for low vision aids is $100 or more, authorization must be obtained from the following:

- California Children's Services, in accordance with CCR, Section 51013, when the recipient is under, or a candidate for, case management by that program
- The Department of Health Care Services' (DHCS') Vision Services Branch (VSB) for:
  - Low vision aids recommended by the Department of Rehabilitation in accordance with CCR, Title 22, Section 51014
  - Low vision aids prescribed for recipients in accordance with CCR, Title 22, Section 51317(f)

Note: Low vision aids with billed amounts less than $100 do not require authorization but are subject to post-service evaluation prior to reimbursement. Claims should include medical justification as listed under "Required Information" in this section.

Low vision aids with billed amounts $100 or greater require authorization. A valid TAR will serve as the required medical justification. Therefore, medical justification does not have to be included with these claims.

To request authorization, providers submit a 50-3 TAR form with medical justification to the VSB as listed under "Required Information" in this section.

Refer to the *TAR Completion for Vision Care* section in this manual for additional information about the authorization process.

Note: Low vision devices that require a TAR must not be billed on the same claim with low vision devices that do not require a TAR (for example, when the billed amount is less than $100). TAR and non-TAR items must be submitted on separate claim forms.

Manual Pricing

When billing low vision aids (HCPCS codes V2600, V2610 and V2615), an invoice or catalog page showing the wholesale cost of the item must be attached to the claim for manual pricing. Claims for low vision aids without an attached invoice or catalog page will be denied regardless of authorization status. An attached invoice or catalog page is not required when requesting authorization from the VSB.

Eye Appliance Items With No Price on File

All eye appliance items with no price on file are manually priced based on invoice or catalog page. Providers have a choice of whether the pricing is done at the time of TAR adjudication or at the time of claim processing.

In order to have pricing done at the time of TAR adjudication, the provider must include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at the Department of Health Care Services Vision Services Branch (VSB) will determine the price and assign a Pricing Indicator (PI) of 3. When this is done, the claim can be submitted without the invoice or catalog page. Providers must enter the 10-digit TCN followed by the PI of 3 (eleventh digit) in the Prior Authorization Number field (Box 23) of the *CMS-1500* claim.

In order to have pricing done at the time of claim processing, the provider does not have to include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at VSB will assign a PI of 0. When this is done, the claim must be submitted with the invoice or catalog page. Providers must enter the 10-digit TCN followed by the PI of 0 (eleventh digit) in *Prior Authorization Number* field (Box 23) of the *CMS-1500* claim.

Note: Authorization of “By Report” procedure codes is only a determination that the appliance and associated services are medically necessary. Determination of reimbursement fees in each case will be made by Medi-Cal. If a TAR is approved, a claim associated with that TAR that fails to meet other Medi-Cal billing requirements may be denied.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.