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Texas Medicaid

Provider Procedures Manual

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Provider Handbooks

Vision and Hearing Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

VISION AND HEARING SERVICES HANDBOOK

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VISION AND HEARING SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for optometrists (doctors of optometry), ophthalmologists, and opticians who render services related to the eye and vision and for hearing aid professionals (fitters and dispensers, physicians, and audiologists) who provide hearing evaluations or fitting and dispensing services. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with Subsection 4.1, "Enrollment". In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol.2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8., "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

2. NONIMPLANTABLE HEARING AID DEVICES AND RELATED SERVICES

2.1 Enrollment

To enroll in Texas Medicaid, hearing aid professionals (physicians, audiologists, and hearing aid fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed. Hearing aid providers are eligible to enroll as individuals and facilities. Audiologists are eligible to enroll as individuals and groups. Audiologists may enroll as both audiologists and as hearing aid fitters and dispensers by completing an enrollment application for each type of provider (i.e., select "Audiologist" on one application and "Hearing Aid" on the other application).

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

2.1.1 School Districts, State Agencies, and Inpatient Facilities

To be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss (other than audiology evaluation and therapy services reimbursed to School Health and Related Services [SHARS] providers), audiologists employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or group practitioners by choosing "Audiologist" on the enrollment application.

To be reimbursed for hearing aid devices and accessories, and fitting and dispensing visits and revisits, audiologists and hearing aid fitters and dispensers employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or facilities by choosing "Hearing Aid" on the enrollment application.

Appropriately-licensed providers who want to provide both audiology services and hearing aid fitting and dispensing services must complete applications for audiologist and for hearing aid fitter and dispenser for each program for which they want to enroll.

Note: *A SHARS Texas Provider Identifier (TPI) cannot be used to bill for these services.*

2.2 Services, Benefits, Limitations, and Prior Authorization

The Texas Medicaid hearing services benefit includes those services that are medically necessary for clients of any age who have suspected or identified hearing loss that can be improved or ameliorated using a hearing aid device. Such services may be reimbursed to audiologists or hearing aid fitters and dispensers.

Note: *Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a nonimplantable hearing aid device are not considered part of the Texas Medicaid hearing services benefit. Providers may refer to the other* Texas Medicaid Provider Procedures Manual *Handbooks for benefit and limitation information about other hearing-related services.*

Texas Medicaid clients of any age are eligible to receive medically necessary hearing aid devices and services through the hearing services benefit outlined in the following sections. The Texas Medicaid hearing services benefit includes a broad range of hearing services for clients of all ages and reimburses providers who are appropriately enrolled with Texas Medicaid in accordance with their licensure and scope of practice. Prior authorization is not necessary for benefits within program limitations unless specifically addressed in the sections below.

The following hearing services are benefits of Texas Medicaid to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians according to their licensure, scope of practice, and enrollment as indicated:

- Audiologists and physicians may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss.
- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories and fitting and dispensing visits and revisits.
- Physicians may be reimbursed for physician otology and otorhinolaryngology (ENT) services.

Texas Medicaid clients whose jobs are contingent on their possessing a hearing aid or who appear to have vocational potential and who need a hearing aid may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS) for hearing aids.

2.2.1 Limitations and Required Forms

All services provided to Texas Medicaid clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations. In addition to services that always require prior authorization, providers may request prior authorization for medically necessary services that exceed benefit limitations.

Required forms, which are indicated in the specific sections below, are not required to be submitted with the claim, but the forms must be completed and maintained in the client's medical record and made available upon request by the Texas Health and Human Services Commission (HHSC) or the Texas Medicaid & Healthcare Partnership (TMHP) for retrospective review.

2.2.2 Hearing Screenings

Hearing screening provided due to client concern, or at the provider's discretion, is a benefit for clients of any age when the client is referred by a Medicaid-enrolled physician, and the screening is provided by a Medicaid-enrolled provider licensed to perform these services.

Routine newborn hearing screenings and Texas Health Steps (THSteps) medical checkup hearing screenings are benefits for Texas Medicaid clients, and are included in the reimbursement for the routine service or visit.

2.2.2.1 Routine Hearing Screenings

Routine hearing screenings that are required as part of the newborn hospital stay and as part of a THSteps medical checkup are included in the Texas Medicaid hearing services benefit. These routine screenings are not reimbursed to audiologists, hearing aid fitters and dispensers, or physicians.

Newborn Hearing Screen
The newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay and is not reimbursed separately. A newborn hearing screening must be offered to each newborn by the facility where the birth occurs, through a program mandated by the Texas State Legislature and certified by the Texas Department of State Health Services (DSHS). The screening is covered as part of the newborn delivery. An infant born outside a birthing facility and not admitted to a birthing facility shall be referred to a facility that provides newborn hearing screening. If a facility is not required by legislative mandate to perform newborn hearing screening, a referral must be made to a facility that offers the screening.

Refer to: Subsection 5.3.7, "Newborn Examination" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the newborn hearing screening.

THSteps Medical Checkup Hearing Screen
Hearing screening is a required component of the THSteps medical checkup, and a standardized audiometric hearing screening is required at specific ages according to the periodicity schedule.

Refer to: The THSteps Medical Checkups Periodicity Schedule including the footnotes, which is available on the DSHS website at www.dshs.state.tx.us/thsteps/providers.shtm, for coverage criteria when performed as part of a THSteps medical checkup.

Subsection 5.3.9.2.3, "Hearing Screening" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks)* for more information on THSteps checkup hearing screening.

2.2.2.2 Additional Hearing Screenings

A hearing screening requested outside of a routine newborn or THSteps medical checkup may be reimbursed as medically necessary without prior authorization using procedure code 92551.

Further diagnostic testing may also be reimbursed using the appropriate procedure code as indicated in subsection 2.2.3, "Audiology and Audiometry Evaluation and Diagnostic Services" in this handbook

2.2.2.3 Abnormal Hearing Screening Results

If the screening returns abnormal results, the client must be referred to a Texas Medicaid-enrolled provider who is a licensed audiologist or physician who provides audiology services. Clients who are 20 years of age or younger and have abnormal screening results must be referred to a Texas Medicaid-enrolled provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record. A new Physician's Examination Report must be completed whenever there is a change in the client's hearing or a new hearing aid is needed. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

In addition to being referred to an appropriate provider for further testing, clients who are 35 months of age and younger and have suspected hearing loss must be referred to Early Childhood Intervention (ECI) within 2 working days of identification, even if the client was referred to an appropriate provider for further testing.

Refer to: Subsection 2.5, "Early Childhood Intervention (ECI) Services" in *Children's Services Handbook* (*Vol. 2, Providers Handbooks*) for more information about ECI.

2.2.3 Audiology and Audiometry Evaluation and Diagnostic Services

Audiometry is a benefit of Texas Medicaid for clients of any age. Physicians must recommend hearing evaluations based on examination of the client. Only physicians or licensed audiologists will be reimbursed for hearing evaluations. Hearing aid fitters and dispensers are not reimbursed for hearing evaluations.

Important: *The date of service for audiology and audiometry evaluations and diagnostic services is the date the service is rendered to the client. The date of service that is billed on the claim must match the date of service that is documented in the client's medical record.*

The following audiometry procedure codes are benefits of Texas Medicaid for a basic comprehensive audiometry survey:

Procedure Codes						
92550	92551	92552	92553	92555	92556	92557

The following additional procedure codes may be benefits for audiometric testing:

Procedure Codes									
92558	92563	92565	92567	92568	92570	92571	92572	92575	92576
92578	92579	92582	92583	92584	92585	92586	92587	92588	

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP web site at www.tmhp.com for procedure codes that may be reimbursed to individual types of providers.

Auditory brainstem response (ABR) and otoacoustic emissions (OAE) are benefits for clients of any ages when performed to identify and diagnose hearing loss and for newborns when performed for the purpose of a newborn hearing screening.

Note: ABR and OAE tests performed as part of the newborn hearing screen are reimbursed as part of the hospital visit and are not reimbursed separately.

2.2.3.1 Otological Examinations

Otological examinations are a benefit when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

Procedure codes 92504 and 92505 are benefits for otological examinations.

An otological examination may also include physician evaluation and management (E/M) services provided to diagnose or treat medical conditions.

Refer to: Subsection 8.2.60.4, "Group Clinical Visits" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

2.2.3.2 Vestibular Evaluations

Vestibular evaluations are a benefit when medically necessary and provided by a Medicaid-enrolled physician or nonphysician provider licensed to perform this service.

The following procedure codes for vestibular evaluations are benefits:

Procedure Codes									
92531	92532	92533	92534	92540	92541	92542	92543	92544	92545
92546	92547								

2.2.3.3 Forms and Documentation

Providers of hearing evaluations must have a report in the client's record. Providers must include in the report hearing evaluation test data. The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the physician or audiologist who conducts the diagnostic testing. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

For physician diagnostic hearing services (procedure codes 92502, 92504, 92540, and 95920), providers must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

2.2.3.4 Prior Authorization

Hearing screening and testing services do not require prior authorization. Documentation of medical necessity must be maintained by the provider in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

2.2.3.5 Limitations

Newborn hearing screenings provided during the birth admission are considered part of the newborn delivery payment to the facility and are not reimbursed as separate procedures.

An otological examination is a benefit of Texas Medicaid when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

An otological examination may also include physician E/M services provided to diagnose or treat medical conditions.

Refer to: Subsection 8.2.60.4, "Group Clinical Visits" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

Audiometry survey procedure codes and evoked potential and otoacoustic emissions screening procedure codes may be reimbursed once per day.

Procedure code 92568 may be reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes									
2251	3510	3511	3518	3519	38600	38601	38602	38603	38604
38610	38611	38612	38619	3862	38630	38631	38632	38633	38634
38635	38640	38641	38642	38643	38648	38650	38651	38652	38653

Diagnosis Codes									
38654	38655	38656	38658	3868	3869	3870	3871	3872	3878
3879	3882	38830	38831	38832	38840	38841	38842	38843	38844
38845	3885	38900	38901	38902	38903	38904	38905	38906	38910
38911	38912	38913	38914	38915	38916	38917	38918	38920	38921
38922	3898	3899	7443	7804					

Providers may bill only one of the pure tone audiometry procedure codes (92551, 92252, and 92553) per day, any provider.

Procedure codes 92553 and 92556 are not reimbursed on the same day by any provider. If these procedure codes are billed for the same date of service, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Tympanometry
Tympanometry (procedure code 92567) must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment. Tympanometry is limited to three services per rolling year when billed by any provider and is based on medical necessity, which must be documented in the client's medical record.

Electrical Testing
Electrical testing may be reimbursed for services rendered to clients of any age.

Electrical testing (procedure code 92547) must be billed with the same date of service by the same provider as procedure code 92541, 92542, 92543, 92544, 92545, or 92546.

Vestibular Evaluation
Vestibular evaluation is a benefit of Texas Medicaid when medically necessary and provided by a provider who is licensed to provide this service.

Hearing pathway tests such as audiometry, ABR, and electrocochleography (ECoG) can also be used for the same purpose and are frequently combined with vestibular tests.

ABR and OAE Hearing Screening Services
Evoked response testing (procedure codes 92558, 92585, 92586, 92587, and 92588) is considered a bilateral procedure. If separate charges are billed for left- and right-sided tests of the same type, the tests are combined and reimbursed as a quantity of one. An electroencephalogram (EEG) may be reimbursed for the same date of service as evoked response testing by any provider.

Procedure code 92591 may be reimbursed as often as is medically necessary.

Texas Medicaid may reimburse physicians for ear and throat examination procedure codes 92502, 92504, and 92540. Audiologists will not be reimbursed for these services.

Refer to: Subsection 8.2.60, "Physician Evaluation and Management (E/M) Services" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about these services.

Procedure code 95920 may be reimbursed in addition to each evoked potential test. Procedure code 95920 is limited to a maximum of 2 hours per day, per client, per provider, without documentation of medical necessity.

2.2.3.6 SHARS Audiology Services

Audiology evaluation and therapy services procedure codes 92506, 92507, and 92508 may be reimbursed to school districts and state agencies that are enrolled with Texas Medicaid as SHARS providers.

Refer to: Section 3., "School Health and Related Services (SHARS)" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about SHARS services.

Other hearing evaluation, diagnostic, and hearing aid services may be reimbursed to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians as outlined in this section.

2.2.3.7 Noncovered Services

Texas Medicaid does not reimburse for a hearing screening completed for day care, Head Start, or school unless it is part of an acute-care visit in a clinic setting. Separate procedure codes must not be billed for these services.

2.2.4 Hearing Aid Devices and Accessories (Nonimplantable)

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following devices and accessories:

Service	Limitation
Hearing aid devices	**Limitation:** 1 per ear every 5 years from the month it is despensed. One of the following may be reimbursed: • For monaural procedure codes, bill a quantity of 1 with the LT modifier and a quantity of 1 with the RT modifier as medically necessary. • For binaural procedure codes, bill a quantity of 1. Replacement hearing aid devices that are required within the same 5-year period must be prior authorized. Repairs or modifications may be reimbursed without prior authorization once per year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. **Procedure codes:** See below for monaural and binaural procedure codes. Procedure code V5014 may be reimbursed for repairs and modifications. **Date of service:** The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. ***Note:*** *During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid will not reimburse hearing aid repairs or modifications that are rendered during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.*
Hearing aid accessories	**Limitation:** As often as is medically necessary for clients who are 20 years of age and younger with prior authorization. ***Note:*** *Hearing aid accessories include, but are not limited to, chin straps, clips, boots, and headbands.* **Procedure code:** V5267 **Date of service:** The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device or the date the client receives the replacement accessory item.

Service	Limitation
Ear impression Ear mold	**Limitation:** 1 each per hearing aid device as follows: • For one impression or ear mold, bill a quantity of 1. • For two impressions or ear molds, bill a quantity of 2. Replacement ear molds may be reimbursed as often as is medically necessary without prior authorization. Documentation of medical necessity must be maintained in the client's medical record. **Procedure codes:** V5264, V5265, and V5275 **Date of service:** The date of service for the ear impression is the date the ear impression is taken.
Batteries (Replacement only)	**Limitation:** Replacement batteries may be reimbursed as often as is medically necessary when a hearing aid device has been previously reimbursed by Texas Medicaid. ***Note:*** *If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity.* **Procedure code:** V5266 **Date of service:** The date of service is the date the client receives the replacement batteries.

The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements when they are billed with the appropriate modifier LT or RT to indicate for which ear the hearing aid device was purchased and fitted:

Procedure Codes									
V5030	V5040	V5170	V5180	V5244	V5245	V5246	V5247	V5254	V5255
V5256	V5257	V5298							

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements:

Procedure Codes									
V5100	V5210	V5220	V5249	V5250	V5251	V5252	V5253	V5258	V5259
V5260	V5261	V5298							

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

Note: *Procedure codes V5251, V5267, and V5298 are manually priced and identified in the fee schedule with "Note Code 5."*

Refer to: "Section 2.4.2, "Reimbursement" in this handbook for more information about manual pricing.

2.2.4.1 Forms and Documentation

Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following documentation of medical necessity must be maintained in the client's medical record:

- Hearing loss in the better ear of 35 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz
- A spondee threshold in the better ear of 35 dBHL or greater when pure tone thresholds cannot be established
- Hearing loss in each ear is less than 35 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance

Clients meet the criteria for binaural aids if they meet the conditions for a monaural hearing aid and have at least a 35-dBHL hearing loss in both ears.

Providers must also include the model number, serial number, and warranty dates of the purchased hearing aid device in the client's medical record.

Refer to: Subsection 6.3.1.1, "Place of Service (POS) Coding" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for more information about coding place of service for other locations.

2.2.4.2 Prior Authorization

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the table above.

Prior authorization is required for the following:

- ***Replacement hearing aid devices that are required within the same 5-year period.***
  A replacement hearing aid device may be considered for prior authorization when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the prior authorization request. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.
- ***Hearing aid accessories for clients who are birth through 20 years of age.***
  Requests for prior authorization for children's hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands will be considered when the requests are submitted with documentation that shows that the client is birth through 20 years of age and that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.
- ***Hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age.***
  The prior authorization request must include:
  - The medical necessity for the requested hearing aid device.
  - The name of the manufacturer.
  - The Manufacturer's Suggested Retail Price (MSRP) or Average Wholesale Price (AWP) or the provider's documented invoice cost.
  - The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.

- Additional medically necessary repairs or modifications beyond 1 per year.
  For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair.

For services that require prior authorization, prior authorization must be obtained before the services are rendered. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization requests must be submitted to the TMHP Special Medical Prior Authorization (SMPA) Department with documentation that supports medical necessity for the requested device, service, or supply. Authorization may be submitted on the TMHP website at www.tmhp.com or by fax to (512) 514-4213.

Important: *For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet benefit criteria, the TMHP SMPA Department will refer the request to the TMHP Coordinated Care Program (CCP) Department for consideration under CCP. The provider is not required to complete additional forms or request referral to the TMHP CCP Department.*

Providers may use the form of their choice to submit the required information to the TMHP SMPA Department. No specific request form is required.

Refer to: Subsection , "Section 6: Claims Filing" (*Vol 1, General Information*) for more information about the authorizations and claims filing processes.

2.2.4.3 Limitations

The following services and supplies must be provided to Texas Medicaid clients if a nonimplantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The re-assessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

A hearing aid dispensed through Texas Medicaid must meet the following criteria:

- Be a new and current model
- Meet the performance specifications indicated by the manufacturer
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.

Providers must dispense each hearing aid reimbursed through Texas Medicaid with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted)
- Manufacturer's postage and handling charges
- All necessary hearing aid accessories or supplies
- Instructions for care and use

- A 1-month supply of batteries

Note: *TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from manufacturers and vendors of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.*

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age.

Procedure code V5251 may be reimbursed with prior authorization for clients who are birth through 20 years of age.

Services for residents in a skilled nursing facility (SNF), , or extended care facility (ECF) must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

2.2.5 Hearing Aid Services

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following services:

Service	Limitation
Hearing test for sensitivity	**Limitation:** As often as is medically necessary **Procedure code:** 92564 (SISI hearing test)
Hearing aid assessment	**Limitation:** As often as is medically necessary **Procedure code:** V5010
Fitting and dispensing visits	**Limitation:** 1 fitting per hearing aid procedure code, regardless of the number of times a device is returned as unacceptable during a 30-day trial period **Procedure code:** V5011 **Limitation:** 1 dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins **Procedure codes:** V5090, V5110, V5160, V5200, V5240, and V5241 The dispensing fee may be reimbursed separately from the fitting of the hearing aid. The post-fitting check is included in the reimbursement for the dispensing procedure and is not reimbursed separately.
Revisit(s)	**Limitation:** 2 per calendar year when billed by any provider **Procedure codes:** 92592 (first and second revisits for monaural fittings) and 92593 (first and second revisits for binaural fittings)

2.2.5.1 Forms and Documentation

The forms and documentation required for the fitting and dispensing visits are as follows:

- Physician Examination Report
- Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)
- Client acknowledgement statement (created by the provider)
- 30-day trial period certification statement (created by the provider)
- Additional necessary documentation

Physician's Examination Report—The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record.

Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)—The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the fitter/dispenser that conducts the fitting and dispensing visit. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation to support improved communication ability with amplification. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Client Acknowledgement Statement (created by the provider)—At the time the hearing aid device and supplies are dispensed, the client must sign a client acknowledgement statement to verify the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need. The acknowledgement statement must include language that indicates the client is responsible for paying any hearing aid rental fees if charged. The provider must obtain the signed acknowledgment statement before dispensing the hearing aid device and supplies and must keep the signed acknowledgment statement in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

30-Day Trial Period Certification Statement (created by the provider)—Fitters and Dispensers must inform clients in writing of the trial period lasting 30 consecutive days. The statement, which must be created by the provider and signed by the client, must contain the start and end dates of the trial period, all charges and fees associated with the trial period, an acknowledgment that the client accepts responsibility for any assessed rental fees, and the name, address, and telephone number of the State Board of Examiners for Speech-Language Pathology and Audiology. The client must receive a copy of this agreement.

After at least 30 days and the successful completion of the trial period, the provider must update the statement to indicate that the trial was successful and the client accepted the dispensed hearing aid device. The updated statement must be maintained in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

2.2.5.2 Prior Authorization

Prior authorization is not required for fitting and dispensing visits and revisits.

2.2.5.3 Limitations

The following hearing aid visits may be reimbursed by Texas Medicaid:

- The fitting and dispensing visits that encompass a 30-day trial period and include a post-fitting check 5 weeks after the trial period has been successfully completed
- A first revisit as needed after the post-fitting check
- A second revisit as needed after the first revisit

The fitting visit includes the fitting, dispensing, and post-fitting check of the hearing aid.

Providers must allow each Texas Medicaid client a 30-consecutive-day trial period that begins with the dispensing date. This trial period gives the client time to determine whether the hearing aid device meets the client's needs. If the client is not satisfied with the purchased hearing aid, the client may return it to the provider, who must accept it. If the device is returned within 30 days of the date it was dispensed, the provider may charge the client a rental fee not to exceed $2 per day. This fee is not a benefit of Texas Medicaid and will not be reimbursed. The client is responsible for paying the hearing aid rental fees if the provider chooses to charge a fee for the rental of returned hearing aid devices.

During the trial period, providers may dispense additional hearing aids as medically necessary until either the client is satisfied with the results of the hearing aid or the provider determines that the client cannot benefit from the dispensing of another hearing aid. The dispensing date of each additional hearing aid starts a new trial period.

The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within 5 weeks of the initial fitting.

The first and second revisits are available if additional visits are required after the post-fitting check.

- ***First revisit.*** The first revisit must include a hearing aid check.
- ***Second revisit.*** The second revisit is available as needed after the post-fitting check and first revisit. The second revisit must include either a real ear measurement or aided sound field testing according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry readings from the first evaluation.

Home visit hearing evaluations and fittings are permitted only with the physician's written recommendation.

Services for residents in an SNF, ICF, or ECF must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

2.3 Documentation Requirements

All services, including hearing services, require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

Required forms for nonimplantable hearing devices and services, which are indicated in the specific sections above, are not submitted with the claim to TMHP, but the forms must be completed and maintained in the client's medical record and made available upon request by HHSC or TMHP for retrospective review.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Filing

Hearing 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.

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

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 1.5.9, "Billing Clients" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

To be reimbursed for both audiology services and hearing aid fitting and dispensing services, audiologists must enroll with Texas Medicaid as audiologists and also as hearing aid fitters and dispensers. Audiology services must be billed using the audiologist provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Audiologist," and hearing aid and fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Hearing Aid."

Providers must file all claims electronically or on the appropriate Centers for Medicare & Medicaid Services (CMS) paper claim form after providing the services. Claims must include the following information:

- The most appropriate 3- to 5-digit *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code that represents the purpose for the service.
- The most appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code(s) that represent the service(s) provided.
- The appropriate information as indicated on the provider enrollment letter (Electronic claims must also include the most appropriate attested taxonomy code.)

Note: *For Texas Medicaid managed care clients, all hearing aid benefits and otology, and audiometry services are administered by the client's Medicaid managed care organization (MCO).*

2.4.1.1 Third Party Liability

Standard third party liability (TPL) rules apply to all hearing services claims.

Refer to: Subsection 4.13, "Third Party Liability (TPL)" "Client Eligibility" (*Vol. 1, General Information*).

2.4.2 Reimbursement

Hearing aids and audiological services are reimbursed in accordance with 1 TAC §355.8141.

Hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider's documented invoice cost if there is no MSRP available.

Manually priced items are indicated with "Note Code 5" in the Texas Medicaid fee schedule.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3. IMPLANTABLE HEARING DEVICES AND RELATED SERVICES

3.1 Enrollment

To enroll in Texas Medicaid, hearing services professionals who provide implantable hearing devices and services must be appropriately enrolled according to their licensure and scope of practice.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

3.2 Services, Benefits, Limitations and Prior Authorization

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone anchored hearing aid (BAHA), are benefits of Texas Medicaid for clients of all ages.

The following services and supplies must be provided to Texas Medicaid clients if an implantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The reassessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

3.2.1 Cochlear Implants

The following procedure codes may be reimbursed for the cochlear implant device, separate components, and services:

Procedure Codes									
69930	L7368	L8499	L8614	L8615	L8616	L8617	L8618	L8619	L8621
L8622	L8623	L8624	L8627	L8628	L8629				

The following procedure codes may be reimbursed for diagnostic analysis of the cochlear implant:

Procedure Codes			
92601	92602	92603	92604

3.2.1.1 Prior Authorization

Prior authorization is required for the following:

- Cochlear implant surgery, device, and replacement parts

- Sound processor repair or replacement
- Battery recharger unit
- Replacement batteries beyond the limitations outlined in the sections below

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Documentation submitted for review must indicate who will be providing the cochlear implant device (i.e., the facility or the Durable Medical Equipment (DME) or medical supplier). The supplier's provider number must be included on the prior authorization request.

Prior authorization for a unilateral or bilateral cochlear implant may be granted for clients who are 12 months of age and older with documentation of all of the following criteria:

- Cognitive ability to use auditory cues and written documentation of agreement by the client or the client's parent or guardian that the client will participate in a program of post-implantation aural rehabilitation. This documentation must be maintained in the client's medical record.
- Postlingual deafness or prelingual deafness.
- Freedom from middle-ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.
- No contraindications to surgery.
- Inability to derive benefit from appropriately fitted hearing aid devices.
- Documentation of poor speech discrimination and a recommendation for cochlear implant candidacy and one of the following diagnoses for severe-to-profound bilateral sensorineural hearing loss:

Diagnosis Codes						
38910	38911	38912	38914	38916	38918	38922

The initial lithium ion battery recharger unit, additional medically necessary units, and additional replacement batteries beyond the limitations indicated in the following sections may be reimbursed with prior authorization. Documentation must be submitted with the prior authorization request to support medical necessity for the request.

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.1.2 Limitations

Surgery
Procedure code 69930 with the appropriate modifier LT or RT may be reimbursed for unilateral cochlear implantation. Procedure code 69930 with modifier 50 may be reimbursed for bilateral cochlear implantation performed simultaneously.

Device and Components
Procedure codes L8627, L8628, and L8629 for the cochlear implant device and components may be reimbursed for clients who are 12 months of age and older as follows:

- The device must be approved by the Food and Drug Administration (FDA) and be age-appropriate for the client.
- One per day may be reimbursed with prior authorization.

The cochlear implant device and the surgery to implant the device may be reimbursed separately.

Replacement Batteries and Related Items
Replacement batteries and related items for the cochlear implant device include non-rechargeable batteries, rechargeable batteries, and recharger units as follows:

Procedure Code	Prior Authorization	Limitation
L8621 (Zink air non-rechargeable)	Not required	Maximum of 50 per month
L8622 (Alkaline non-rechargeable)	Not required	Maximum of 31 per month
L8623 (Lithium ion rechargeable)	Not required	2 batteries per calendar year
L8624 (Lithium ion rechargeable)	Not required	2 batteries per calendar year
L7368 (Battery recharger unit for lithium ion rechargeable batteries)	Required	1 replacement unit every 5 rolling years

Replacement batteries for clients with bilateral cochlear implants and two sound processors may be reimbursed when billed with the applicable battery procedure code and the appropriate LT or RT modifier.

Replacement batteries for the cochlear device are limited to clients with a previously billed cochlear implant procedure, device, or supply. Replacement batteries for clients who did not receive the cochlear implant through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting medical necessity.

Additional batteries and lithium ion battery recharger units beyond these limitations may be reimbursed with prior authorization.

Speech Therapy
Speech therapy is a benefit of Texas Medicaid and can be billed separately from the surgical fee for the cochlear implant as follows:

- For clients who are 12 months through 20 years of age, speech therapy is provided through the CCP.
- For clients who are 21 years of age and older, speech therapy is payable through Texas Medicaid when billed by the hospital or the physician.
- The service is considered to be included in the inpatient DRG payment when provided in an inpatient facility or inpatient rehabilitation setting.

Refer to: Subsection 3.3.9, "Speech Therapy (ST)" in *Children's Services Handbook (Vol. 2, Provider Handbooks).*

Subsection 4.2.3, "ST and Aural Rehabilitation Services" in *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about speech therapy benefits.

Frequency modulated (FM) systems are not benefits of Texas Medicaid.

3.2.2 Auditory Brainstem Implant (ABI)

The following procedure codes may be reimbursed for the ABI, related components, and services:

Procedure Codes					
92640	L8499	L8614	L8621	L8622	S2235

3.2.2.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- ABI surgery, device, and replacement parts
- Sound processor repair or replacement
- Replacement batteries beyond the limitations outlined in the sections below

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Prior authorization requests and claims for ABI must be submitted with diagnosis code 23772 and 23773.

Refer to: Subsection 2.2.1, "Limitations and Required Forms" in this handbook for additional information about replacement batteries.

Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.2.2 Limitations

ABI is a benefit for clients who are 12 years of age and older.

Diagnostic analysis of the ABI (procedure code 92640) is limited to 2 hours per day when billed by any provider.

3.2.3 Bone-Anchored Hearing Aid (BAHA)

The following procedure codes must be submitted for the BAHA and related components:

Procedure Codes								
69714	69715	69717	69718	L8690	L8691	L8692	L8693	V5266

3.2.3.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- BAHA implant surgery, device, and replacement parts
- Sound processor repair or replacement

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Prior authorization requests may be granted for clients who are 5 years of age and older with all of the following:

- Documentation of previous attempts at hearing aid devices and why these devices are inadequate or have failed
- Documentation of scores on hearing tests for bone conduction thresholds and on maximum speech discrimination
- Documentation of audiological testing showing good inner ear function
- Documentation of a multidisciplinary assessment including physical, cognitive, communicative, and behavioral limitations describing the client's auditory disability and expected benefit with use of the BAHA implant

- Documentation of an appropriate diagnosis. Covered diagnoses may include, but are not limited to:

Diagnosis Codes						
38901	38902	38908	38915	74401	74402	7560

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.3.2 Limitations

BAHAs are a benefit for clients who are 5 years of age and older.

Replacement batteries for the BAHA (procedure code V5266) do not require prior authorization. The replacement batteries are limited to clients with a previously billed hearing device. Replacement batteries for clients who did not receive the hearing device through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting the medical necessity.

Procedure codes L8691, L8692, and L8693 will be denied as part of another service when billed by any provider with the same date of service as procedure code L8690.

Procedure code L8692 for the BAHA device and components may be reimbursed once per day with prior authorization.

Bilateral BAHA procedures are not benefits of Texas Medicaid.

3.2.4 Sound Processor Replacement and Repair

3.2.4.1 Prior Authorization

Replacement and repair of a sound processor require prior authorization.

Documentation by the physician must explain the need for the replacement of the sound processor. The processor must be used for a minimum of 12 months before replacement of the unit will be considered.

The prior authorization request must include evidence of the purchase, such as the manufacturer's warranty.

Repair of a sound processor will be considered for prior authorization with documentation of medical necessity for the requested repair. Repair of a sound processor will be manually priced at the time the prior authorization is reviewed and granted. If the actual cost of the repair differs from the prior authorized fee, the provider must contact the SMPA Department to update the authorization before filing a claim for the repair services.

3.2.4.2 Limitations

Procedure code L8499 with modifier RB may be reimbursed for sound processor repair.

Repair or replacement of a sound processor is not a benefit during the manufacturer's warranty period.

3.3 Documentation Requirements

All implantable hearing aid services require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.4 Claims Filing and Reimbursement

3.4.1 Claims Filing

Hearing 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.

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

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 1.5.9, "Billing Clients" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Note: *For Texas Medicaid managed care clients, all implantable hearing devices and services are administered by the client's Medicaid MCO.*

3.4.1.1 Third Party Liability

Standard TPL rules apply to all hearing services claims.

Refer to: Subsection 4.13, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

3.4.2 Reimbursement

Implantable hearing aids and related services are reimbursed in accordance with 1 TAC §355.8141.

Implantable hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider's documented invoice cost. Manually priced items are indicated with "MP" in the reimbursement rate table at the end of this article.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

3.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4. VISION CARE PROFESSIONALS

4.1 Enrollment

To enroll in Texas Medicaid, optometrists (doctors of optometry [ODs]) and ophthalmologists must be licensed by the licensing board of their profession to practice in the state where the service is performed, at the time the service is performed, and be enrolled as Medicare providers.

An optometrist or ophthalmologist cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Provider Responsibilities

Suppliers of eyewear must comply with all Medicaid provider responsibilities and adhere to the following guidelines:

- Do not delay the ordering of eyewear or the dispensing of eyeglasses to the client while payment is pending from TMHP.
- Deliver the eyewear in a reasonable amount of time (usually two or three weeks from the date the order is placed by the client).
- Obtain the required eligibility information from the client's Your Texas Benefits Medicaid card.
- Refer to the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com to determine whether eyeglasses have been reimbursed by Texas Medicaid within the last 24 months. Providers are advised to ask clients if they have recently received vision care services that may not appear on the Your Texas Benefits Medicaid card website because of the delay in updating form information.
- Submit claims for eyewear services as soon as possible so the client's record indicates that eyewear or eyeglasses have been dispensed.
- Have the client, parent, or guardian sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in their records. When a client chooses an eyeglass or contact lens option beyond the program limitations, or if nonprosthetic eyeglasses or contact lenses are replaced because of loss or destruction, the client must acknowledge their choice and his/her liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form. The form must remain in the provider's records.
- Do not charge a Medicaid client more than a patient not enrolled in Texas Medicaid for noncovered services (e.g., tints, oversized lenses, or frames).
- Keep invoices on file for a minimum of five years.
- Submit claims using the date eyeglasses were ordered as the date of service (DOS) (the start of the 95-day filing period), not the date the eyewear was dispensed.

4.3 Services, Benefits, Limitations, and Prior Authorization

Examination and treatment of eye conditions, including prescribing and dispensing of medically necessary eyeglasses or contact lenses, are benefits of Texas Medicaid and may be reimbursed to optometrist, ophthalmologist, and optician providers as is within the scope of practice for each.

The following services are included in other services and will not be considered for separate reimbursement:

- Vision screening conducted to meet State screening requirements, such as the DSHS School Vision and Hearing Screening Program.
- Expenses for medical supplies, equipment, and other items that are not specifically made-to-order for the client are considered to have been incurred on the date the item is delivered.

Ophthalmologist and Optometrist
Examination and treatment services rendered by an ophthalmologist or optometrist are not limited to the procedure codes included in this handbook.

Refer to: The Texas Medicaid fee schedules on the TMHP web site at www.tmhp.com for a complete list of procedure codes that may be reimbursed by Texas Medicaid.

Optician
Services rendered by an optician are limited to fitting and dispensing of medically necessary eyeglasses and contact lenses.

Note: *In accordance with the Omnibus Reconciliation Act of 1986, Section 9336, a Doctor of Optometry is considered a physician, with respect to the provision of any item or service the optometrist is authorized to perform by state law or regulation.*

4.3.1 Services Performed in Long-Term Care Facilities

Ophthalmological, optometric, and eyeglass or contact lens services provided in a skilled or intermediate care facility may be reimbursed when the client's attending physician has ordered the service and the signed order is included in the client's medical record at the nursing facility.

The ordering physician's name and provider identifier must be documented on the claim when ophthalmological, optometric, or eyeglasses or contact lenses services are performed in a skilled or intermediate care facility.

4.3.2 Services Performed in Federally Qualified Healthcare Centers (FQHC)

Vision services rendered by FQHC providers may be reimbursed based on an all-inclusive rate per visit.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about vision services that may be reimbursed to FQHC providers.

4.3.3 THSteps Medical Checkup Vision Screening

A vision screening must be completed during each THSteps medical checkup with standardized screenings performed at specific ages, as listed in the THSteps Periodicity Schedule. Providers may perform a vision screening during an acute care visit with the appropriate screening tools or refer at-risk infants and children to an optometrist or ophthalmologist who is experienced with the pediatric population and who can perform further testing, diagnosis, and treatment.

Refer to: Subsection 5.3.9.2.4, "Vision Screening" in *Children's Services Handbook (Vol. 2, Provider Handbooks)* for information about THSteps medical checkup vision screenings.

4.3.3.1 Vision Screening Outside of a THSteps Preventive Care Medical Checkup

Vision screening for clients who are birth through 20 years of age may be completed at any office visit upon the following:

- Request from a parent
- Referral from a school vision screening program
- Referral from a school nurse

Clients with abnormal screening results must be referred to an appropriate provider. Clients who are birth through 20 years of age and who are at high risk for eye problems should be referred to an ophthalmologist who is experienced with the pediatric population.

4.3.4 Noncovered Services

The following services and supplies are not a benefit of Texas Medicaid:

- Artificial eyes for clients who are 21 years of age and older.
- Eyeglasses for residents of institutions where the reimbursement formula and vendor reimbursement include this service.
- Eyeglasses or contact lenses prescribed or dispensed to clients at a hospital or nursing facility without documented orders of the attending physician in the client's medical records.
- Low vision aids.
- Optional eyeglass features that are requested by the client but that do not increase visual acuity (e.g., lens tint, industrial hardening, and decorative accessories or lettering).
- Plano sunglasses.
- Prisms that are ground into the lenses.
- Replacement of lost or destroyed nonprosthetic eyeglasses or contact lenses for clients who are 21 years of age and older.
- Repair of eyeglasses for clients who are 21 years of age and older.
- Extended color vision examination (procedure code 92283), dark adaptation examination (procedure code 92284), and vision screening (procedure code 99172 or 99173).
- Vision services for clients who are 21 years of age and older that exceed the limitation of one eye examination by refraction, for each client, every 24 months (This limitation does not apply to medically necessary eye examinations for clients who are 21 years of age and older with a diagnosis of diabetes.)
- Contact lens prescription services, except for the treatment of aphakia (congenital or acquired) or injury to the eye.
- Spectacle (eyeglass) fitting services.

Clients may be billed for noncovered frames and other items beyond Medicaid benefits. Providers must have the client sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records. The client payment amount is not considered other insurance and must not be entered as a credit amount in the electronic field.

Example: *Texas Medicaid may reimburse providers a total of $30.36 for eyeglass frames that are within the provider's selection for Medicaid reimbursement plus the allowed cost per lens. If the client chooses a pair of frames (such as $200 frames) that are outside of the provider's selections for Medicaid reimbursement and if the client chooses other items or services that are not a benefit of Texas Medicaid (such as tinted lenses for an extra $10*

charge), the client is responsible for and may be billed for the balance of the cost of the frames ($169.64) and the other items that are not a benefit of Medicaid ($10 for tinted lenses).

The provider may withhold the noncovered eyewear, contacts, or eyeglasses until the client pays for those items. If the client fails to pay for the noncovered items or has not returned for finished eyewear within a reasonable length of time (two to three months), the provider may return any reusable items to stock. Any payment made by TMHP for frames or lenses must be refunded to Texas Medicaid. If a client requests eyewear that is beyond program benefits (for example, scratch-resistant coating), Medicaid allows reimbursement up to the maximum fee. The provider may charge the client the difference between the Medicaid payment and the customary charge for the eyewear requested, when the client has been shown the complete selection of Medicaid-covered eyewear and when the following conditions are met:

- The client rejects the Medicaid-covered eyewear and wants eyewear that complies with Texas Medicaid specifications, but is not included in the selection of Medicaid-covered eyewear.
- The client indicates a willingness to pay the difference between the Medicaid payment and the actual charge. The provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records.

Note: *A client who requires low vision aids or who experiences vision-related difficulty with daily living activities or with employment may be referred to the DARS Division for Blind Services for evaluation and any appropriate resources.*

4.3.5 Vision Testing

Vision testing and examination and treatment of eye conditions are benefits of Texas Medicaid and may be reimbursed to ophthalmologist or optometrist providers.

Eye examinations and refraction testing may be reimbursed using the following procedure codes:

Procedure Codes						
92002	92004	92012	92014	92015	S0620	S0621

Refer to: Subsection 8.2.60.1.1, "New and Established Patient Services" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about new patient and established patient E/M services.

Vision testing procedure codes are subject to the CMS NCCI relationships. Claims that are submitted by physicians with the same specialty who are in the same group practice are processed as if they were the same provider. Providers should refer to the *Current Procedural Terminology (CPT) Manual* for additional information about intermediate and comprehensive ophthalmological services.

The following relationships are exceptions to the published NCCI relationships:

The procedure codes in Column A of the table below will be denied if they are billed with the same date of service by the same provider as the procedure codes in Column B:

Column A (Denied)	Column B
S0620, S0621	92002, 92004, 92012, 92014

Note: *Physicians with the same specialty who are in the same group practice are subject to the same limitations as if they were the same provider.*

Refer to: The CMS NCCI web page at www.cms.hhs.gov/NationalCorrectCodInitEd/ for the published correct coding guidelines and specific applicable code combinations.

4.3.5.1 Routine Vision Testing

Procedure codes S0620 and S0621 may be reimbursed for routine vision testing with refraction when they are billed with one of the following diagnosis codes:

Diagnosis Codes									
24941	24950	24951	24960	24961	24970	24971	24980	24981	24990
24991	25000	25001	25002	25003	25010	25011	25012	25013	25020
25021	25022	25023	25030	25031	25032	25033	25040	25041	25042
25043	25050	25051	25052	25053	25060	25061	25062	25063	25070
25071	25072	25073	25080	25081	25082	25083	25090	25091	25092
25093	36201	36202	36203	36204	36205	36206	36207	36220	36222
36223	36224	36225	36226	36227	3670	3671	36720	36721	36722
36731	36732	3674	36751	36752	36753	36781	36789	3679	37182
V720									

Clients who are birth through 20 years of age are eligible for an eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every state fiscal year (September 1 through August 31). The limitation for refraction testing can be exceeded for clients who are birth through 20 years of age only when:

- The parent, teacher, or school nurse requests the refraction testing and it is medically necessary.
- There is a significant change in vision, and documentation supports a diopter (d) change of 0.5d or greater in the sphere, cylinder, or prism measurements.

Clients who are 21 years of age and older are eligible for an eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every two state fiscal years (September 1 through August 31). The limitation for refraction testing can be exceeded for clients who are 21 years of age and older only when there is a significant change in vision, and documentation supports a diopter change of 0.5d or more in the sphere, cylinder, or prism measurements.

4.3.5.2 Medically Necessary Eye Examinations

An eye examination with or without refraction (procedure code 92002, 92004, 92012, 92014, or 92015) may be reimbursed as often as is medically necessary for the treatment of or to prescribe eyeglasses or contact lenses for aphakia, eye disease, or eye injury.

Documentation in the client's medical record must support the medical necessity of the service performed.

Procedure codes 92002, 92004, 92012, 92014, and 92015 may be reimbursed as often as is medically necessary to ophthalmologist or optometrist providers for medically necessary eye examinations without refraction.

Claims billed by optometrists must include one of the following diagnosis codes:

Diagnosis Codes									
05320	05321	05322	05329	05440	05441	05442	05443	05444	05449
0760	0761	0769	0770	0771	0772	0773	0774	0778	07798
07799	0903	0905	0906	0907	0909	09150	09151	09152	09840
09841	09842	09843	09849	11502	11512	11592	1301	1302	1900
1901	1902	1903	1904	1905	1906	1907	1908	1909	2240

Diagnosis Codes									
2241	2242	2243	2244	2245	2246	2247	2248	2249	2340
24900	24901	24910	24911	24920	24921	24930	24931	24940	24941
24950	24951	24960	24961	24970	24971	24980	24981	24990	24991
25000	25001	25002	25003	25010	25011	25012	25013	25020	25021
25022	25023	25030	25031	25032	25033	25040	25041	25042	25043
25050	25051	25052	25053	25060	25061	25062	25063	25070	25071
25072	25073	25080	25081	25082	25083	25090	25091	25092	25093
36000	36001	36002	36003	36004	36011	36012	36013	36014	36019
36020	36021	36023	36024	36029	36030	36031	36032	36033	36034
36040	36041	36042	36043	36044	36050	36051	36052	36053	36054
36055	36059	36060	36061	36062	36063	36064	36065	36069	36081
36089	3609	36100	36101	36102	36103	36104	36105	36106	36107
36110	36111	36112	36113	36114	36119	3612	36130	36131	36132
36133	36181	36189	3619	36201	36202	36203	36204	36205	36206
36207	36210	36211	36212	36213	36214	36215	36216	36217	36218
36220	36221	36222	36223	36224	36225	36226	36227	36229	36230
36231	36232	36233	36234	36235	36236	36237	36240	36241	36242
36243	36250	36251	36252	36253	36254	36255	36256	36257	36260
36261	36262	36263	36264	36265	36266	36482	36500	36501	36502
36503	36504	36505	36506	36510	36511	36512	36513	36514	36515
36520	36521	36522	36523	36524	36531	36532	36541	36542	36543
36544	36551	36552	36559	36560	36561	36562	36563	36564	36570
36571	36572	36573	36574	36581	36582	36583	36589	3659	3670
3671	36720	36721	36722	36731	36732	3674	36751	36752	36753
36781	36789	3679	36800	36801	36802	36803	36810	36811	36812
36813	36814	36815	36816	3682	36830	36831	36832	36833	36834
36840	36841	36842	36843	36844	36845	36846	36847	36851	36852
36853	36854	36855	36859	36860	36861	36862	36863	36869	3688
3689	36900	36901	36902	36903	36904	36905	36906	36907	36908
36910	36911	36912	36913	36914	36915	36916	36917	36918	36920
36921	36922	36923	36924	36925	3693	3694	36960	36961	36962
36963	36964	36965	36966	36967	36968	36969	36970	36971	36972
36973	36974	36975	36976	3698	3699	37000	37001	37002	37003
37004	37005	37006	37007	37020	37021	37022	37023	37024	37031
37032	37033	37034	37035	37040	37044	37049	37050	37052	37054
37055	37059	37060	37061	37062	37063	37064	3708	3709	37100
37101	37102	37103	37104	37105	37110	37111	37112	37113	37114
37115	37116	37120	37121	37122	37123	37124	37130	37131	37132
37133	37140	37141	37142	37143	37144	37145	37146	37148	37149
37150	37151	37152	37153	37154	37155	37156	37157	37158	37160

Diagnosis Codes									
37161	37162	37170	37171	37172	37173	37181	37182	37189	3719
37200	37201	37202	37203	37204	37205	37206	37210	37211	37212
37213	37214	37215	37220	37221	37222	37230	37231	37233	37234
37239	37240	37241	37242	37243	37244	37245	37250	37251	37252
37253	37254	37255	37256	37261	37262	37263	37264	37271	37272
37273	37274	37275	37281	37289	3729	37300	37301	37302	37311
37312	37313	3732	37331	37332	37333	37334	3734	3735	3736
3738	3739	37400	37401	37402	37403	37404	37405	37410	37411
37412	37413	37414	37420	37421	37422	37423	37430	37431	37432
37433	37434	37441	37443	37444	37445	37446	37450	37451	37452
37453	37454	37455	37456	37481	37482	37483	37484	37485	37486
37487	37489	3749	37500	37501	37502	37503	37511	37512	37513
37514	37515	37516	37520	37521	37522	37530	37531	37532	37533
37541	37542	37543	37551	37552	37553	37554	37555	37556	37557
37561	37569	37581	37589	37600	37601	37602	37603	37604	37610
37611	37612	37613	37621	37622	37630	37631	37632	37633	37634
37635	37636	37640	37641	37642	37643	37644	37645	37646	37647
37650	37651	37652	3766	37681	37682	37689	3769	37700	37701
37702	37703	37704	37710	37711	37712	37713	37714	37715	37716
37721	37722	37723	37724	37730	37731	37732	37733	37734	37739
37741	37742	37743	37749	37751	37752	37753	37754	37761	37762
37763	37771	37772	37773	37775	3779	37991	37992	37993	74300
74303	74306	74310	74311	74312	74320	74321	74322	74330	74331
74332	74333	74334	74335	74336	74337	74339	74341	74342	74343
74344	74345	74346	74347	74348	74349	74351	74352	74353	74354
74355	74356	74357	74358	74359	74361	74362	74363	74364	74365
74366	74369	7438	7439	7840	8700	8701	8702	8703	8704
8708	8709	8710	8711	8712	8713	8714	8715	8716	8717
8719	9180	9181	9182	9189	9210	9211	9212	9213	9219
9300	9301	9302	9308	9309	9400	9401	9402	9403	9404
9405	9409	V431	V5861	V5862	V5863	V5864	V5865	V5866	V5867
V5869	V720								

Procedure code 92015 may be reimbursed to ophthalmologist or optometrist providers for refraction in addition to the eye examination procedure code 92002, 92004, 92012, or 92014.

If one of the following is true, an E/M procedure code may be reimbursed for an eye examination when the most appropriate procedure code is billed with one of the diagnosis codes in the above table:

- The examination does not meet the elements of an intermediate or comprehensive level of service as defined by procedure codes 92002, 92004, 92012, and 92014.
- A highly complex or risk-prone eye examination is performed.
- The client is seen for a medical reason that does not require any eye examination.

Refer to: Subsection 8.2.60.1, "Office or Other Outpatient Hospital Services" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about E/M services and procedure codes.

4.3.5.3 Ophthalmological Examination and Evaluation with General Anesthesia

An ophthalmological examination and evaluation under general anesthesia may be medically necessary when a client has significant injury or cannot otherwise tolerate the procedure while conscious.

Procedure codes 92018 and 92019 may be reimbursed separately for the general anesthesia.

Procedure codes 92018 and 92019 may be reimbursed once per service, per day, when billed by any provider.

4.3.5.4 Ophthalmic Ultrasound

Ophthalmic ultrasound is an ultrasonic diagnostic test that uses high frequency sound waves that are used to provide additional information about the interior of the eye and surrounding areas. The following procedure codes may be reimbursed for ophthalmic ultrasound services:

Procedure Codes								
76510	76511	76512	76513	76514	76516	76519	76529	76999

One of the following diagnosis codes must be submitted with the most appropriate ophthalmic ultrasound procedure code:

Diagnosis Codes									
1900	1901	1984	2240	2241	2340	2388	23981	24941	24950
24951	24960	24961	24970	24971	24980	24981	24990	24991	25050
25051	25052	25053	36050	36051	36052	36053	36054	36055	36059
36060	36061	36062	36063	36064	36065	36069	36100	36101	36102
36103	36104	36105	36106	36107	36110	36111	36112	36113	36114
36119	3612	36130	36131	36132	36133	36181	36189	3619	36201
36202	36203	36204	36205	36206	36207	36210	36211	36212	36213
36214	36215	36216	36217	36218	36220	36221	36222	36223	36224
36225	36226	36227	36229	36230	36231	36232	36233	36234	36235
36236	36237	36240	36241	36242	36243	36250	36251	36252	36253
36254	36255	36256	36257	36260	36261	36262	36263	36264	36265
36266	36270	36271	36272	36273	36274	36275	36276	36277	36281
36282	36283	36284	36285	36289	36340	36341	36342	36343	36361
36362	36363	36370	36371	36372	36441	36481	36482	36489	36600
36601	36602	36603	36604	36609	36610	36611	36612	36613	36614
36615	36616	36617	36618	36619	36620	36621	36622	36623	36630
36631	36632	36633	36634	36641	36642	36643	36644	36645	36646
36650	36651	36652	36653	3668	3669	37100	37101	37102	37103
37104	37105	37110	37111	37112	37113	37114	37115	37116	37120
37121	37122	37123	37124	37130	37131	37132	37133	37140	37141
37142	37143	37144	37145	37146	37148	37149	37150	37151	37152
37153	37154	37155	37156	37157	37158	37160	37161	37162	37170

Diagnosis Codes									
37171	37172	37173	37181	37182	37189	3719	3766	37921	37926
37931	37932	37933	37934	37939	37992	74330	74331	74332	74333
74334	74335	74336	74337	74339	8704	8715	8716	9300	9301
9302	9308	9309							

Ophthalmic ultrasounds may be reimbursed when they are billed with the same date of service by the same provider as an eye examination visit or consultation.

Ophthalmic ultrasounds (procedure codes 76514, 76516, and 76519) are limited to one service, per day, by any provider.

Exception: *Procedure codes 76514, 76516, and 76519 may be reimbursed once per day when they are billed by any provider.*

Ophthalmic ultrasound procedure codes are subject to CMS NCCI relationships. The following relationships are exceptions to the published NCCI relationships:

The procedure codes listed in Column A of the table below will be denied when they are billed with the same date of service by the same provider as the corresponding procedure codes in Column B.

Column A (Denied)	Column B
76511	76506, 76510, 76512
76512	76510
76516	76511, 76519
76519	76511
76529	76512, 76513

Refer to: The CMS NCCI web page at www.cms.hhs.gov/NationalCorrectCodInitEd/ for the published correct coding guidelines and specific applicable code combinations.

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

- A clear, concise description of the ophthalmic ultrasound being performed.
- A diagnosis from the diagnosis table in the ophthalmic ultrasound section above.
- A procedure code that is comparable to the ophthalmic ultrasound being requested or the provider's intended fee for performing the ophthalmic ultrasound.

Note: *Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.*

4.3.5.5 Corneal Topography

Procedure code 92025 may be reimbursed for corneal topography when it is billed with one of the following diagnosis codes:

Diagnosis Codes									
37000	37001	37002	37003	37004	37005	37006	37007	37100	37101
37102	37103	37104	37120	37121	37122	37123	37140	37141	37142
37146	37148	37149	37160	37161	37162	37170	37171	37172	37173
37234	37240	37241	37242	37243	37244	37245	37281	37289	74341

Diagnosis Codes								
8710	8711	9402	9403	9404	99651	V425	V4561	V4569

Corneal topography may be reimbursed when it is billed with the same date of services by the same provider as an eye examination visit or consultation.

Corneal topography (procedure code 92025) is limited to one service, per day, by any provider.

4.3.5.6 Sensorimotor Examination

A sensorimotor examination with interpretation and report consists of multiple ocular deviation measurements and includes, but is not limited to, visual motor integration, reversal frequency (letters and numbers), motor speed and precision, visual memory, and visualization to test eye movement and control, focusing ability, eye teaming ability, depth perception, and visual perception skills.

Procedure code 92060 may be reimbursed for a sensorimotor examination when it is billed with one of the following diagnosis codes:

Diagnosis Codes									
36800	36801	36802	36803	37800	37801	37802	37803	37804	37805
37806	37807	37808	37810	37811	37812	37813	37814	37815	37816
37817	37818	37820	37821	37822	37823	37824	37830	37831	37832
37833	37834	37835	37840	37841	37842	37843	37844	37845	37850
37851	37852	37853	37854	37855	37856	37860	37861	37862	37863
37871	37872	37873	37883	37950	37951	37952	37953	37954	37955
37956	37957	37958	37959						

Procedure code 92060 may be reimbursed once per day and twice per calendar year when it is billed by any provider.

4.3.5.7 Orthoptic and Pleoptic Training

Orthoptics, a component of vision training or vision therapy, are exercises designed to improve the function of the eye muscles with an emphasis on binocular vision and eye movements. Pleoptics are exercises designed to improve impaired vision when there is no evidence of organic eye diseases.

Procedure code 92065 may be reimbursed for orthoptic or pleoptic training when it is billed with one of the following diagnosis codes:

Diagnosis Codes									
36800	36801	36802	36803	37800	37801	37802	37803	37804	37805
37806	37807	37808	37810	37811	37812	37813	37814	37815	37816
37817	37818	37820	37821	37822	37823	37824	37830	37831	37832
37833	37834	37835	37840	37841	37842	37843	37844	37845	37850
37851	37852	37853	37854	37855	37856	37860	37861	37862	37863
37871	37872	37873	37883	37950	37951	37952	37953	37954	37955
37956	37957	37958	37959						

Procedure code 92065 may be reimbursed once per day and twice per calendar year when it is billed by any provider.

4.3.5.8 Ophthalmoscopy, Angioscopy or Angiography

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated and may be reimbursed using the following procedure codes:

Procedure Codes						
92225	92226	92230	92235	92240	92250	92260

Ophthalmoscopy and fluorescein angioscopy or angiography (procedure codes 92225, 92226, 92230, and 92235) are considered unilateral procedures and may be reimbursed for a quantity of two if both the left and right eyes are evaluated. If two services are billed for the same date of service, one may be reimbursed at the full rate, and the other may be reimbursed at half rate.

Procedure codes 92225 and 92226 may be reimbursed once per eye, per day when they are billed by any provider.

Procedure codes 92225 and 92226 must be billed with modifier LT or RT to identify the eye on which the service was performed.

Ophthalmoscopy, angioscopy, and angiography procedure codes are subject to CMS NCCI relationships.

In addition to CMS NCCI relationships, the procedure codes in Column A of the following table will be denied if they are billed with the same date of service by the same provider as the corresponding procedure codes in Column B:

Column A (Denied)	Column B
92132, 92133, 92134	92250
92230	92235
92240	92230, 92250

Refer to: The CMS NCCI web page at www.cms.hhs.gov/NationalCorrectCodInitEd/ for the published correct coding guidelines and specific applicable code combinations.

4.3.5.9 Other Professional Services

The following procedure codes may be reimbursed by Texas Medicaid when the services are medically necessary:

Procedure Codes									
92020	92081	92082	92083	92100	92132	92133	92134	92136	92140
92227	92228	92265	92270	92275	92285	92286	92287		

Procedure codes 92227 and 92228 may each be reimbursed once per day.

Visual field examination procedure codes 92081, 92082, 92083 may be reimbursed twice per calendar year when billed by any provider.

Procedure codes 92132, 92133, and 92134 may be reimbursed once per day, when it is billed by any provider.

Scanning computerized ophthalmic diagnostic imaging (procedure codes 92132, 92133, and 92134) are limited to one service per day, any provider.

Serial automounter (procedure code 92100), ophthalmic biometry (procedure code 92136), and provocative tests for glaucoma (procedure code 92140) may be reimbursed once per day when they are billed by any provider.

External ocular photography (procedure code 92285) may be reimbursed once per day, when it is billed by any provider.

Procedure codes 92285, 92286, and 92287 may be reimbursed when they are billed with one of the following diagnosis codes:

Infectious and Parasitic Diseases

Diagnosis Codes									
0010	0011	0019	0020	0021	0022	0023	0029	0030	0031
00320	00321	00322	00323	00324	00329	0038	0039	0040	0041
0042	0043	0048	0049	0050	0051	0052	0053	0054	00581
00589	0059	0060	0061	0062	0063	0064	0065	0066	0068
0069	0070	0071	0072	0073	0074	0075	0078	0079	00800
00801	00802	00803	00804	00809	0081	0082	0083	00841	00842
00843	00844	00845	00846	00847	00849	0085	00861	00862	00863
00864	00865	00866	00867	00869	0088	0090	0091	0092	0093
01000	01001	01002	01003	01004	01005	01006	01010	01011	01012
01013	01014	01015	01016	01080	01081	01082	01083	01084	01085
01086	01090	01091	01092	01093	01094	01095	01096	01100	01101
01102	01103	01104	01105	01106	01110	01111	01112	01113	01114
01115	01116	01120	01121	01122	01123	01124	01125	01126	01130
01131	01132	01133	01134	01135	01136	01140	01141	01142	01143
01144	01145	01146	01150	01151	01152	01153	01154	01155	01156
01160	01161	01162	01163	01164	01165	01166	01170	01171	01172
01173	01174	01175	01176	01180	01181	01182	01183	01184	01185
01186	01190	01191	01192	01193	01194	01195	01196	01200	01201
01202	01203	01204	01205	01206	01210	01211	01212	01213	01214
01215	01216	01220	01221	01222	01223	01224	01225	01226	01230
01231	01232	01233	01234	01235	01236	01280	01281	01282	01283
01284	01285	01286	01300	01301	01302	01303	01304	01305	01306
01310	01311	01312	01313	01314	01315	01316	01320	01321	01322
01323	01324	01325	01326	01330	01331	01332	01333	01334	01335
01336	01340	01341	01342	01343	01344	01345	01346	01350	01351
01352	01353	01354	01355	01356	01360	01361	01362	01363	01364
01365	01366	01380	01381	01382	01383	01384	01385	01386	01390
01391	01392	01393	01394	01395	01396	01400	01401	01402	01403
01404	01405	01406	01480	01481	01482	01483	01484	01485	01486
01500	01501	01502	01503	01504	01505	01506	01510	01511	01512
01513	01514	01515	01516	01520	01521	01522	01523	01524	01525
01526	01550	01551	01552	01553	01554	01555	01556	01560	01561
01562	01563	01564	01565	01566	01570	01571	01572	01573	01574
01575	01576	01580	01581	01582	01583	01584	01585	01586	01590
01591	01592	01593	01594	01595	01596	01600	01601	01602	01603

Diagnosis Codes									
01604	01605	01606	01610	01611	01612	01613	01614	01615	01616
01620	01621	01622	01623	01624	01625	01626	01630	01631	01632
01633	01634	01635	01636	01640	01641	01642	01643	01644	01645
01646	01650	01651	01652	01653	01654	01655	01656	01660	01661
01662	01663	01664	01665	01666	01670	01671	01672	01673	01674
01675	01676	01690	01691	01692	01693	01694	01695	01696	01700
01701	01702	01703	01704	01705	01706	01710	01711	01712	01713
01714	01715	01716	01720	01721	01722	01723	01724	01725	01726
01730	01731	01732	01733	01734	01735	01736	01740	01741	01742
01743	01744	01745	01746	01750	01751	01752	01753	01754	01755
01756	01760	01761	01762	01763	01764	01765	01766	01770	01771
01772	01773	01774	01775	01776	01780	01781	01782	01783	01784
01785	01786	01790	01791	01792	01793	01794	01795	01796	01800
01801	01802	01803	01804	01805	01806	01880	01881	01882	01883
01884	01885	01886	01890	01891	01892	01893	01894	01895	01896
0200	0201	0202	0203	0204	0205	0208	0209	0210	0211
0212	0213	0218	0219	0220	0221	0222	0223	0228	0229
0230	0231	0232	0233	0238	0239	024	025	0260	0261
0269	0270	0271	0272	0278	0279	0300	0301	0302	0303
0308	0309	0310	0311	0312	0318	0319	0320	0321	0322
0323	03281	03282	03283	03284	03285	03289	0329	0330	0331
0338	0339	0340	0341	035	0360	0361	0362	0363	03640
03641	03642	03643	03681	03682	03689	0369	037	0380	03810
03811	03819	0382	0383	03840	03841	03842	03843	03844	03849
0388	0389	0390	0391	0392	0393	0394	0398	0399	0400
0401	0402	0403	04081	04082	04089	04100	04101	04102	04103
04104	04105	04109	04110	04111	04119	0412	0413	0414	0415
0416	0417	04181	04182	04183	04184	04185	04186	04189	0419
042	04500	04501	04502	04503	04510	04511	04512	04513	04520
04521	04522	04523	04590	04591	04592	04593	0460	0461	0462
0463	0468	0469	0470	0471	0478	0479	048	0490	0491
0498	0499	0500	0501	0502	0509	0510	0511	0512	0519
0520	0521	0527	0528	0529	0530	05310	05311	05312	05313
05319	05320	05321	05322	05329	05371	05379	0538	0539	0540
05410	05411	05412	05413	05419	0542	0543	05440	05441	05442
05443	05444	05449	0545	0546	05471	05472	05473	05479	0548
0549	0550	0551	0552	05571	05579	0558	0559	05600	05601
05609	05671	05679	0568	0569	0570	0578	0579	05810	05811
05812	05821	05829	05881	05882	05889	0600	0601	0609	061
0620	0621	0622	0623	0624	0625	0628	0629	0630	0631

Diagnosis Codes									
0632	0638	0639	064	0650	0651	0652	0653	0654	0658
0659	0660	0661	0662	0663	06640	06641	06642	06649	0668
0669	0700	0701	07020	07021	07022	07023	07030	07031	07032
07033	07041	07042	07043	07044	07049	07051	07052	07053	07054
07059	0706	07070	07071	0709	071	0720	0721	0722	0723
07271	07272	07279	0728	0729	0730	0737	0738	0739	0740
0741	07420	07421	07422	07423	0743	0748	075	0760	0761
0769	0770	0771	0772	0773	0774	0778	07798	07799	0780
07810	07811	07819	0782	0783	0784	0785	0786	0787	07881
07882	07888	07889	0790	0791	0792	0793	0794	07950	07951
07952	07953	07959	0796	07981					

Endocrine, Nutritional and Metabolic, Immunity

Diagnosis Codes									
25000	25001	25002	25003	25010	25011	25012	25013	25020	25021
25022	25023	25030	25031	25032	25033	25040	25041	25042	25043
25050	25051	25052	25053	25060	25061	25062	25063	25070	25071
25072	25073	25080	25081	25082	25083	25090	25091	25092	25093
29010	29011	29012	29013	29020	29021	2903	29040	29041	29042

Metabolic Disorders

Diagnosis Codes									
29043	2908	2909	2910	2911	2912	2913	2914	2915	29181
29182	29189	2919	2920	29211	29212	2922	29281	29282	29283
29284	29285	29289	2929	2930	2931	29381	29382	29383	29384
29389	2939	2940	29410	29411	2948	2949	29500	29501	29502
29503	29504	29505	29510	29511	29512	29513	29514	29515	29520
29521	29522	29523	29524	29525	29530	29531	29532	29533	29534
29535	29540	29541	29542	29543	29544	29545	29550	29551	29552
29553	29554	29555	29560	29561	29562	29563	29564	29565	29570
29571	29572	29573	29574	29575	29580	29581	29582	29583	29584
29585	29590	29591	29592	29593	29594	29595	29600	29601	29602
29603	29604	29605	29606	29610	29611	29612	29613	29614	29615
29616	29620	29621	29622	29623	29624	29625	29626	29630	29631
29632	29633	29634	29635	29636	29640	29641	29642	29643	29644
29645	29646	29650	29651	29652	29653	29654	29655	29656	29660
29661	29662	29663	29664	29665	29666	2967	29680	29681	29682
29689	29690	29699	2970	2971	2972	2973	2978	2979	2980
2981	2982	2983	2984	2988	2989	29900	29901	29910	29911
29980	29981	29990	29991	30000	30001	30002	30009	30010	30011

Diagnosis Codes									
30012	30013	30014	30015	30016	30019	30020	30021	30022	30023
30029	3003	3004	3005	3006	3007	30081	30082	30089	3009
3010	30110	30111	30112	30113	30120	30121	30122	3013	3014
30150	30151	30159	3016	3017	30181	30182	30183	30184	30189
3019	3020	3021	3022	3023	3024	30250	30251	30252	30253
3026	30270	30271	30272	30273	30274	30275	30276	30279	30281
30282	30283	30284	30285	30289	3029	30300	30301	30302	30303
30390	30391	30392	30393	30400	30401	30402	30403	30410	30411
30412	30413	30420	30421	30422	30423	30430	30431	30432	30433
30440	30441	30442	30443	30450	30451	30452	30453	30460	30461
30462	30463	30470	30471	30472	30473	30480	30481	30482	30483
30490	30491	30492	30493	30500	30501	30502	30503	3051	30520
30521	30522	30523	30530	30531	30532	30533	30540	30541	30542
30543	30550	30551	30552	30553	30560	30561	30562	30563	30570
30571	30572	30573	30580	30581	30582	30583	30590	30591	30592
30593	3060	3061	3062	3063	3064	30650	30651	30652	30653
30659	3066	3067	3068	3069	3070	3071	30720	30721	30722
30723	3073	30740	30741	30742	30743	30744	30745	30746	30747
30748	30749	30750	30751	30752	30753	30754	30759	3076	3077
30780	30781	30789	3079	3080	3081	3082	3083	3084	3089
3090	3091	30921	30922	30923	30924	30928	30929	3093	3094
30981	30982	30983	30989	3099	3100	3101	3102	3109	311
31200	31201	31202	31203	31210	31211	31212	31213	31220	31221
31222	31223	31230	31231	31232	31233	31234	31235	31239	3124
31281	31282	31289	3129	3130	3131	31321	31322	31323	3133
31381	31382	31383	31389	3139	31400	31401	3141	3142	3148
3149	31500	31501	31502	31509	3151	3152	31531	31532	31534
31539	3154	3155	3158	3159	316	317	3180	3181	3182
319									

Nervous System and Sense Organs

Diagnosis Codes									
3200	3201	3202	3203	3207	32081	32082	32089	3209	3210
3211	3212	3213	3214	3218	3220	3221	3222	3229	3231
3232	3239	3240	3241	3249	325	326	32700	32701	32702
32709	32710	32711	32712	32713	32714	32715	32719	32720	32721
32722	32723	32724	32725	32726	32727	32729	32730	32731	32732
32733	32734	32735	32736	32737	32739	32740	32741	32742	32743
32744	32749	32751	32752	32753	32759	3278	3300	3301	3302
3303	3308	3309	3310	33111	33119	3312	3313	3314	3317

Diagnosis Codes									
33181	33182	33183	33189	3319	3320	3321	3330	3331	3332
3333	3334	3335	3336	33381	33382	33383	33384	33389	33390
33391	33392	33393	33399	3340	3341	3342	3343	3344	3348
3349	3350	33510	33511	33519	33520	33521	33522	33523	33524
33529	3358	3359	3360	3361	3362	3363	3368	3369	33700
33701	33709	3371	33720	33721	33722	33729	3379	340	3410
3411	3418	3419	34200	34201	34202	34210	34211	34212	34280
34281	34282	34290	34291	34292	3430	3431	3432	3433	3434
3438	3439	34400	34401	34402	34403	34404	34409	3441	3442
34430	34431	34432	34440	34441	34442	3445	34460	34461	34481
34489	3449	34500	34501	34510	34511	3452	3453	34540	34541
34550	34551	34560	34561	34570	34571	34580	34581	34590	34591
34600	34601	34602	34603	34610	34611	34612	34613	34620	34621
34622	34623	34630	34631	34632	34633	34640	34641	34642	34643
34650	34651	34652	34653	34660	34661	34662	34663	34670	34671
34672	34673	34680	34681	34682	34683	34690	34691	34692	34693
34700	34701	34710	34711	3480	3481	3482	34830	34831	34839
3484	3485	34881	34889	3489	3490	3491	3492	34931	34939
34981	34982	34989	3499	3501	3502	3508	3509	3510	3511
3518	3519	3520	3521	3522	3523	3524	3525	3526	3529
3530	3531	3532	3533	3534	3535	3536	3538	3539	3540
3541	3542	3543	3544	3545	3548	3549	3550	3551	3552
3553	3554	3555	3556	35571	35579	3558	3559	3560	3561
3562	3563	3564	3568	3569	3570	3571	3572	3573	3574
3575	3576	3577	35781	35782	35789	3579	35800	35801	3581
3582	3588	3589	3590	3591	3593	3594	3595	3596	35971
35979	35981	35989	3599	36000	36001	36002	36003	36004	36011
36012	36013	36014	36019	36020	36021	36023	36024	36029	36030
36031	36032	36033	36034	36040	36041	36042	36043	36044	36050
36051	36052	36053	36054	36055	36059	36060	36061	36062	36063
36064	36065	36069	36081	36089	3609	36100	36101	36102	36103
36104	36105	36106	36107	36110	36111	36112	36113	36114	36119
3612	36130	36131	36132	36133	36181	36189	3619	36201	36202
36203	36204	36205	36206	36207	36210	36211	36212	36213	36214
36215	36216	36217	36218	36220	36221	36222	36223	36224	36225
36226	36227	36229	36230	36231	36232	36233	36234	36235	36236
36237	36240	36241	36242	36243	36250	36251	36252	36253	36254
36255	36256	36257	36260	36261	36262	36263	36264	36265	36266
36270	36271	36272	36273	36274	36275	36276	36277	36281	36282
36283	36284	36285	36289	3629	36300	36301	36303	36304	36305

Diagnosis Codes									
36306	36307	36308	36310	36311	36312	36313	36314	36315	36320
36321	36322	36330	36331	36332	36333	36334	36335	36340	36341
36342	36343	36350	36351	36352	36353	36354	36355	36356	36357
36361	36362	36363	36370	36371	3638	3639	36400	36401	36402
36403	36404	36405	36410	36411	36421	36422	36423	36424	3643
36441	36442	36451	36452	36453	36454	36455	36456	36457	36459
36460	36461	36462	36463	36464	36470	36471	36472	36473	36474
36475	36476	36477	3649	36500	36501	36502	36503	36504	36505
36506	36510	36511	36512	36513	36514	36515	36520	36521	36522
36523	36524	36531	36532	36541	36542	36543	36544	36551	36552
36559	36560	36561	36562	36563	36564	36565	36570	36571	36572
36573	36574	36581	36582	36583	36589	3659	3670	3671	36720
36721	36722	36731	36732	3674	36751	36752	36753	36781	36789
3679	36800	36801	36802	36803	36810	36811	36812	36813	36814
36815	36816	3682	36830	36831	36832	36833	36834	36840	36841
36842	36843	36844	36845	36846	36847	36851	36852	36853	36854
36855	36859	36860	36861	36862	36863	36869	3688	3689	36900
36901	36902	36903	36904	36905	36906	36907	36908	36910	36911
36912	36913	36914	36915	36916	36917	36918	36920	36921	36922
36923	36924	36925	3693	3694	36960	36961	36962	36963	36964
36965	36966	36967	36968	36969	36970	36971	36972	36973	36974
36975	36976	3698	3699	37000	37001	37002	37003	37004	37005
37006	37007	37010	37020	37021	37022	37023	37024	37031	37032
37033	37034	37035	37040	37044	37049	37050	37052	37054	37055
37059	37060	37061	37062	37063	37064	3708	3709	37100	37101
37102	37103	37104	37105	37110	37111	37112	37113	37114	37115
37116	37120	37121	37122	37123	37124	37130	37131	37132	37133
37140	37141	37142	37143	37144	37145	37146	37148	37149	37150
37151	37152	37153	37154	37155	37156	37157	37158	37160	37161
37162	37170	37171	37172	37173	37181	37182	37189	3719	37200
37201	37202	37203	37204	37205	37206	37210	37211	37212	37213
37214	37215	37220	37221	37222	37230	37231	37233	37234	37239
37240	37241	37242	37243	37244	37245	37250	37251	37252	37253
37254	37255	37256	37261	37262	37263	37264	37271	37272	37273
37274	37275	37281	37289	3729	37300	37301	37302	37311	37312
37313	3732	37331	37332	37333	37334	3734	3735	3736	3738
3739	37400	37401	37402	37403	37404	37405	37410	37411	37412
37413	37414	37420	37421	37422	37423	37430	37431	37432	37433
37435	37441	37443	37444	37445	37446	37450	37451	37452	37453
37454	37455	37456	37481	37482	37483	37484	37485	37486	37487

Diagnosis Codes									
37489	3749	37500	37501	37502	37503	37511	37512	37513	37514
37515	37516	37520	37521	37522	37530	37531	37532	37533	37541
37542	37543	37551	37552	37553	37554	37555	37556	37557	37561
37569	37581	37589	3759	37600	37601	37602	37603	37604	37610
37611	37612	37613	37621	37622	37630	37631	37632	37633	37634
37635	37636	37640	37641	37642	37643	37644	37645	37646	37647
37650	37651	37652	3766	37681	37682	37689	3769	37700	37701
37702	37703	37704	37710	37711	37712	37713	37714	37715	37716
37721	37722	37723	37724	37730	37731	37732	37733	37734	37739
37741	37742	37749	37751	37752	37753	37754	37761	37762	37763
37771	37772	37773	37775	3779	37800	37801	37802	37803	37804
37805	37806	37807	37808	37810	37811	37812	37813	37814	37815
37816	37817	37818	37820	37821	37822	37823	37824	37830	37831
37832	37833	37834	37835	37840	37841	37842	37843	37844	37845
37850	37851	37852	37853	37854	37855	37856	37860	37861	37862
37863	37871	37872	37873	37881	37882	37883	37884	37885	37886
37887	3789	37900	37901	37902	37903	37904	37905	37906	37907
37909	37911	37912	37913	37914	37915	37916	37919	37921	37922
37923	37924	37925	37926	37927	37929	37931	37932	37933	37934
37939	37940	37941	37942	37943	37945	37946	37949	37950	37951
37952	37953	37954	37955	37956	37957	37958	37959	3798	37990
37991	37992	37993	37999	38000	38001	38002	38003	38010	38011
38012	38013	38014	38015	38016	38021	38022	38023	38030	38031
38032	38039	3804	38050	38051	38052	38053	38081	38089	3809
38100	38101	38102	38103	38104	38105	38106	38110	38119	38120
38129	3813	3814	38150	38151	38152	38160	38161	38162	38163
3817	38181	38189	3819	38200	38201	38202	3821	3822	3823
3824	3829	38300	38301	38302	3831	38320	38321	38322	38330
38331	38332	38333	38381	38389	3839	38400	38401	38409	3841
38420	38421	38422	38423	38424	38425	38481	38482	3849	38500
38501	38502	38503	38509	38510	38511	38512	38513	38519	38521
38522	38523	38524	38530	38531	38532	38533	38535	38582	38583
38589	3859	38600	38601	38602	38603	38604	38610	38611	38612
38619	3862	38630	38631	38632	38633	38634	38635	37640	38641
38642	38643	38648	38650	38651	38652	38653	38654	38655	38656
38658	3868	3869	3870	3871	3872	3878	3879	38800	38801
38802	38810	38811	38812	3882	38830	38831	38832	38840	38841
38842	38843	38844	3885	38860	38861	38869	38870	38871	38872
3888	38900	38901	38902	38903	38904	38908	38910	38911	38912
38914	38918	3897	3898	3899					

Circulatory System

Diagnosis Codes									
390	3910	3911	3912	3918	3919	3920	3929	393	3940
3941	3942	3949	3950	3951	3952	3959	3960	3961	3962
3963	3968	3969	3970	3971	3979	3980	39890	39891	39899
4010	4011	4019	40200	40201	40210	40211	40290	40291	40300
40301	40310	40311	40390	40391	40400	40401	40402	40403	40410
40411	40412	40413	40490	40491	40492	40493	40501	40509	40511
40519	40591	40599	41000	41001	41002	41010	41011	41012	41020
41021	41022	41030	41031	41032	41040	41041	41042	41050	41051
41052	41060	41061	41062	41070	41071	41072	41080	41081	41082
41090	41091	41092	4111	4112	41189	412	4130	4131	4139
41400	41401	41402	41403	41404	41405	41406	41410	41411	41412
41419	4148	4149	4150	41511	41519	4160	4161	4162	4168
4169	4170	4171	4178	4179	4200	42090	42091	42099	4210
4211	4219	4220	42290	42291	42292	42293	42299	4230	4231
4238	4239	4240	4241	4242	4243	42490	42491	42499	4250
4252	4253	4254	4255	4257	4258	4259	4260	42610	42611
42612	42613	4262	4263	4264	42650	42651	42652	42653	42654
4266	4267	42681	42682	42689	4269	4270	4271	4272	42731
42732	42741	42742	4275	42760	42761	42769	42781	42789	4279
4280	4281	42820	42821	42822	42823	42830	42831	42832	42833
42840	42841	42842	42843	4289	4290	4291	4292	4293	4294
4295	4296	42971	42979	42981	42982	42989	4299	430	431
4320	4321	4329	43300	43301	43310	43311	43320	43321	43330
43331	43380	43381	43390	43391	43400	43401	43410	43411	43490
43491	4350	4351	4352	4353	4358	4359	436	4370	4371
4372	4373	4374	4375	4376	4377	4378	4379	4380	43810
43811	43812	43813	43814	43819	43820	43821	43822	43830	43831
43832	43840	43841	43842	43850	43851	43852			

Complications of Pregnancy, Childbirth, and Puerperium

Diagnosis Codes									
65980	65981	65983	65990	65991	65993	66000	66001	66003	66010
66011	66020	66021	66023	66030	66031	66033	66040	66041	66043
66050	66051	66053	66060	66061	66063	66070	66071	66073	66080
66081	66083	66090	66091	66093	66100	66101	66103	66110	66111
66113	66120	66121	66123	66130	66131	66133	66140	66141	66143
66190	66191	66193	66200	66201	66203	66210	66211	66213	66220
66221	66223	66230	66231	66233	66300	66301	66303	66310	66311
66313	66320	66321	66323	66330	66331	66333	66340	66341	66343

Diagnosis Codes									
66350	66351	66353	66360	66361	66363	66380	66381	66383	66390
66391	66393	66400	66401	66404	66410	66411	66414	66420	66421
66424	66430	66431	66434	66440	66441	66444	66450	66451	66454
66480	66481	66484	66490	66491	66494	66500	66501	66503	66510
66511	66520	66522	66524	66530	66531	66534	66540	66541	66544
66550	66551	66554	66560	66561	66564	66570	66571	66572	66574
66580	66581	66582	66583	66584	66590	66591	66592	66593	66594
66600	66602	66604	66610	66612	66614	66620	66622	66624	66630
66632	66634	66700	66702	66704	66710	66712	66714	66800	66801
66802	66803	66804	66810	66811	66812	66813	66814	66820	66821
66822	66823	66824	66880	66881	66882	66883	66884	66890	66891
66892	66893	66894	66900	66901	66902	66903	66904	66910	66911
66912	66913	66914	66920	66921	66922	66923	66924	66930	66932
66934	66940	66941	66942	66943	66944	66950	66951	66960	66961
66970	66971	66980	66981	66982	66983	66984	66990	66991	66992
66993	66994	67000	67002	67004	67010	67012	67014	67020	67022
67024	67030	67032	67034	67080	67082	67084	67100	67101	67102
67103	67104	67110	67111	67112	67113	67114	67120	67121	67122
67123	67124	67130	67131	67133	67140	67142	67144	67150	67151
67152	67153	67154	67180	67181	67182	67183	67184	67190	67191
67192	67193	67194	67200	67202	67204	67300	67301	67302	67303
67304	67310	67311	67312	67313	67314	67320	67321	67322	67323
67324	67330	67331	67332	67333	67334	67380	67381	67382	67383
67384	67400	67401	67402	67403	67404	67410	67412	67414	67420
67422	67424	67430	67432	67434	67440	67442	67444	67480	67482
67484	67490	67492	67494	67500	67501	67502	67503	67504	67510
67511	67512	67513	67514	67520	67521	67522	67523	67524	67580
67581	67582	67583	67584	67590	67591	67592	67593	67594	67600
67601	67602	67603	67604	67610	67611	67612	67613	67614	67620
67621	67622	67623	67624	67630	67631	67632	67633	67634	67640
67641	67642	67643	67644	67650	67651	67652	67653	67654	67660
67661	67662	67663	67664	67680	67681	67682	67683	67684	67690
67691	67692	67693	67694	677	67800	67801	67803	67810	67811
67813	67900	67901	67902	67903	67904	67910	67911	67912	67913
67914									

Skin and Subcutaneous Tissue

Diagnosis Codes									
6800	6801	6802	6803	6804	6805	6806	6807	6808	6809
68100	68101	68102	68110	68111	6819	6820	6821	6822	6823

Diagnosis Codes									
6824	6825	6826	6827	6828	6829	683	684	6850	6851
68600	68601	68609	6861	6868	6869	69010	69011	69012	69018
6908	6910	6918	6920	6921	6922	6923	6924	6925	6926
69270	69271	69272	69273	69274	69275	69276	69277	69279	69281
69282	69283	69284	69289	6929	6930	6931	6938	6939	6940
6941	6942	6943	6944	6945	69460	69461	6948	6949	6950
69510	69511	69512	69513	69514	69515	69519	6952	6953	6954
69550	69551	69552	69553	69554	69555	69556	69557	69558	69559
69581	69589	6959	6960	6961	6962	6963	6964	6965	6968
6970	6971	6978	6979	6980	6981	6982	6983	6984	6988
6989	700	7010	7011	7012	7013	7014	7015	7018	7019
7020	70211	70219	7028	7030	7038	7039	70400	70401	70402
70409	7041	7042	7043	7048	7049	7050	7051	70521	70522
70581	70582	70583	70589	7059	7060	7061	7062	7063	7068
7069	70700	70701	70702	70703	70704	70705	70706	70707	70709
70710	70711	70712	70713	70714	70715	70719	70720	70721	70722
70723	70724	70725	7078	7079	7080	7081	7082	7083	7084
7085	7088	7089	70900	70901	70909	7091	7092	7093	7094
7098	7099								

Musculoskeletal System and Connective Tissue

Diagnosis Codes									
7100	7101	7102	7103	7104	7105	7108	7109	71100	71101
71102	71103	71104	71105	71106	71107	71108	71109	71110	71111
71112	71113	71114	71115	71116	71117	71118	71119	71120	71121
71122	71123	71124	71125	71126	71127	71128	71129	71130	71131
71132	71133	71134	71135	71136	71137	71138	71139	71140	71141
71142	71143	71144	71145	71146	71147	71148	71149	71150	71151
71152	71153	71154	71155	71156	71157	71158	71159	71160	71161
71162	71163	71164	71165	71166	71167	71168	71169	71170	71171
71172	71173	71174	71175	71176	71177	71178	71179	71180	71181
71182	71183	71184	71185	71186	71187	71188	71189	71190	71191
71192	71193	71194	71195	71196	71197	71198	71199	71210	71211
71212	71213	71214	71215	71216	71217	71218	71219	71220	71221
71222	71223	71224	71225	71226	71227	71228	71229	71230	71231
71232	71233	71234	71235	71236	71237	71238	71239	71280	71281
71282	71283	71284	71285	71286	71287	71288	71289	71290	71291
71292	71293	71294	71295	71296	71297	71298	71299	7130	7131
7132	7133	7134	7135	7136	7137	7138	7140	7141	7142
71430	71431	71432	71433	7144	71481	71489	7149	71500	71504

Diagnosis Codes									
71509	71510	71511	71512	71513	71514	71515	71516	71517	71518
71520	71521	71522	71523	71524	71525	71526	71527	71528	71530
71531	71532	71533	71534	71535	71536	71537	71538	71580	71589
71590	71591	71592	71593	71594	71595	71596	71597	71598	71600
71601	71602	71603	71604	71605	71606	71607	71608	71609	71610
71611	71612	71613	71614	71615	71616	71617	71618	71619	71620
71621	71622	71623	71624	71625	71626	71627	71628	71629	71630
71631	71632	71633	71634	71635	71636	71637	71638	71639	71640
71641	71642	71643	71644	71645	71646	71647	71648	71649	71650
71651	71652	71653	71654	71655	71656	71657	71658	71659	71660
71661	71662	71663	71664	71665	71666	71667	71680	71681	71682
71683	71684	71685	71686	71687	71688	71689	71690	71691	71692
71693	71694	71695	71696	71697	71698	71699	7170	7171	7172
7173	71740	71741	71742	71743	71749	7175	7176	7177	71781
71782	71783	71784	71785	71789	7179	71800	71801	71802	71803
71804	71805	71807	71808	71809	71810	71811	71812	71813	71814
71815	71817	71818	7819	71820	71821	71822	71823	71824	71825
71826	71827	71828	71829	71830	71831	71832	71833	71834	71835
71836	71837	71838	71839	71840	71841	71842	71843	71844	71845
71846	71847	71848	71849	71850	71851	71852	71853	71854	71855
71856	71857	71858	71859	71865	71870	71871	71872	71873	71874
71875	71876	71877	71878	7179	71880	71881	71882	71883	71884
71885	71886	71887	71888	71889	71890	71891	71892	71893	71894
71895	71897	71898	71899	71900	71901	71902	71903	71904	71905
71906	71907	71908	71909	71910	71911	71912	71913	71914	71915
71916	71917	71918	71919	71920	71921	71922	71923	71924	71925
71926	71927	71928	71929	71930	71931	71932	71933	71934	71935
71936	71937	71938	71939	71940	71941	71942	71943	71944	71945
71946	71947	71948	71949	71950	71951	71952	71953	71954	71955
71956	71957	71958	71959	71960	71961	71962	71963	71964	71965
71966	71967	71968	71969	71980	71981	71982	71983	71984	71985
71986	71987	71988	71989	71990	71991	71992	71993	71994	71995
71996	71997	71998	71999	7200	7201	7202	72081	72089	7209
7210	7211	7212	7213	72141	72142	7215	7216	7217	7218
72190	72191	7220	72210	72211	7222	72230	72231	72232	72239
7224	72251	72252	7226	72270	72271	72272	72273	72280	72281
72282	72283	72290	72291	72292	72293	7230	7231	7232	7233
7234	7235	7236	7237	7238	7239	72400	72401	72402	72409
7241	7242	7243	7244	7245	7246	72470	72471	72479	7248
7249	725	7260	72610	72611	72612	72619	7262	72630	72631

Diagnosis Codes									
72632	72633	72639	7264	7265	72660	72661	72662	72663	72664
72665	72669	72670	72671	72672	72673	72679	7268	72690	72691
72700	72701	72702	72703	72704	72705	72706	72709	7271	7272
7273	72740	72741	72742	72743	72749	72750	72751	72759	72760
72761	72762	72763	72764	72765	72766	72767	72768	72769	72781
72782	72783	72789	7279	7280	72810	72811	72812	72813	72819
7282	7283	7284	7285	7286	72871	72879	72881	72882	72883
72884	72885	72886	72889	7289	7290	7291	7292	72930	72931
72939	7294	7295	7296	72981	72982	72989	72990	72991	72992
72999	73000	73001	73002	73003	73004	73005	73006	73007	73008
73009	73010	73011	73012	73013	73014	73015	73016	73017	73018
73019	73020	73021	73022	73023	73024	73025	73026	73027	73028
73029	73030	73031	73032	73033	73034	73035	73036	73037	73038
73039	73070	73071	73072	73073	73074	73075	73076	73077	73078
73079	73080	73081	73082	73083	73084	73085	73086	73087	73088
73089	73090	73091	73092	73093	73094	73095	73096	73097	73098
73099	7310	7311	7312	7318	7320	7321	7322	7323	7324
7325	7326	7327	7328	7329	73300	73301	73302	73303	73309
73310	73311	73312	73313	73314	73315	73316	73319	73320	73321
73322	73329	7333	73340	73341	73342	73343	73344	73349	7335
7336	7337	73381	73382	73390	73391	73392	73393	73394	73396
73397	73398	73399	734	7350	7351	7352	7353	7354	7355
7358	7359	73600	73601	73602	73603	73604	73605	73606	73607
73609	7361	73620	73621	73622	73629	73630	73631	73632	73639
73641	73642	7365	7366	73670	73671	73672	73673	73674	73675
73676	73679	73681	73689	7369	7370	73710	73711	73712	73719
73720	73721	73722	73729	73730	73731	73732	73733	73734	73739
73740	73741	73742	73743	7378	7379	7380	73810	73811	73812
73819	7382	7383	7384	7385	7386	7387	7388	7389	7390
7391	7392	7393	7394	7395	7396	7397	7398	7399	

Congenital Anomalies

Diagnosis Codes									
7400	7401	7402	74100	74101	74102	74103	74190	74191	74192
74193	7420	7421	7422	7423	7424	74251	74253	74259	7428
7429	74300	74303	74306	74310	74311	74312	74320	74321	74322
74341	74342	74343	74344	74345	74346	74347	74348	74349	74351
74352	74353	74354	74355	74356	74357	74358	74359	74361	74362
74363	74364	74365	74366	74369	7438	7439	74400	74401	74402
77403	74404	74405	74409	7441	74421	74422	74423	74424	74429

Diagnosis Codes									
7443	74441	74442	74443	74446	74447	74449	7445	74481	74482
74483	74484	74489	7449	7450	74510	74511	74512	74519	7452
7453	7454	7455	74560	74561	74569	7457	7458	7459	74600
74601	74602	74609	7461	7462	7463	7464	7465	7466	7467
74681	74682	74683	74684	74685	74686	74687	74689	7469	7470
74710	74711	74720	74721	74722	74729	74740	74741	74742	74749
7475	74760	74761	74762	74763	74764	74769	74781	74782	74783
74789	7479	7480	7481	7482	7483	7484	7485	74860	74861
74869	7488	7489	74900	74901	74902	74903	74904	74910	74911
74912	74913	74914	74920	74921	74922	74923	74924	74925	7500
75010	75011	75012	75013	75015	75016	75019	75021	75022	75023
75024	75025	75026	75027	75029	7503	7504	7505	7506	7507
7508	7509	7510	7511	7512	7513	7514	7515	75160	75161
75162	75169	7517	7518	7519	7520	75210	75211	75219	7522
75240	75241	75242	75249	75251	75252	75261	75262	75263	75264
75269	7527	75281	75289	7529	7530	75310	75311	75312	75313
75314	75315	75316	75317	75319	75320	75321	75322	75323	75329
7533	7534	7535	7536	7537	7538	7539	7540	7541	7542
75430	75431	75432	75433	75435	75440	75441	75442	75443	75444
75450	75451	75452	75453	75459	75460	75461	75462	75469	75470
75471	75479	75481	75482	75489	75500	75501	75502	75510	75511
75512	75513	75514	75520	75521	75522	75523	75524	75525	75526
75527	75528	75529	75530	75531	75532	75533	75534	75535	75536
75537	75538	75539	7554	75550	75551	75552	75553	75554	75555
75556	75557	75558	75559	75560	75561	75562	75563	75564	75565
75566	75567	75569	7558	7559	7560	75610	75611	75612	75613
75614	75615	75616	75617	75619	7562	7563	7564	75650	75651
75652	75653	75654	75655	75656	75659	7566	75670	75671	75672
75673	75679	75681	75682	75683	75689	7569	7570	7571	7572
75731	75732	75733	75739	7574	7575	7576	7578	7579	7580
7581	7582	75831	75832	75833	75839	7584	7585	7586	7587
75881	75889	7589	7590	7591	7592	7593	7594	7595	7596
7597	75981	75982	75983	75989	7599				

Conditions in the Perinatal Period

Diagnosis Codes									
7600	7601	7602	7603	7604	7605	76061	76062	76063	76064
76070	76071	76072	76073	76074	76075	76076	76077	76078	76079
7608	7609	7610	7611	7612	7613	7614	7615	7616	7617
7618	7619	7620	7621	7622	7623	7624	7625	7626	7627

Diagnosis Codes									
7628	7629	7630	7631	7632	7633	7634	7635	7636	7637

Injury and Poisoning

Diagnosis Codes									
99657	99669	99670	99671	99672	99673	99674	99675	99676	99677
99678	99679	99680	99681	99682	99683	99684	99685	99686	99687
99689	99690	99691	99692	99693	99694	99695	99696	99699	99700
99701	99702	99709	9971	9972	99731	99739	9975	99760	99761
99762	99769	99771	99779	99791	99799	99811	99812	99813	9982
99830	99831	99832	99833	9984	99851	99859	9986	9987	99881
99882	99883	99889	9989	9990	9991	9992	9995	99981	99982
99988	99989	9999							

Factors Influencing Health Status and Contact with Health Services (V Codes)

Diagnosis Codes									
V010	V011	V012	V013	V014	V015	V016	V0171	V0179	V0181
V0183	V0184	V0189	V019	V020	V021	V022	V023	V024	V7649
V7650	V7651	V7652	V7681	V7689	V769	V770	V771	V772	V773
V774	V775	V776	V777	V778	V7791	V7799	V780	V781	V782
V783	V788	V789	V790	V791	V792	V793	V798	V799	V8001
V8009	V801	V802	V803	V810	V811	V812	V813	V814	V815
V816	V820	V821	V822	V823	V824	V825	V826	V8281	V8289
V829									

For other professional services, fitting services are included in the reimbursement for prosthetic eyeglasses or contact lenses.

4.3.6 Vision Services for Nonprosthetic Eyewear

Definition: nonprosthetic eyewear is medically necessary to correct defects in vision. Providers may refer to TAC §354.1015 for more information.

Limitations: Nonprosthetic eyeglasses or contact lenses may be reimbursed for clients of any age when there is no other option available to correct or ameliorate a visual defect. Prescribing and dispensing medically necessary eyeglasses or contact lenses are benefits of Texas Medicaid as follows:

- Nonprosthetic eyeglasses or contact lenses may be reimbursed once every 24 months. Additional services within the 24-month period may be considered when documentation in the client's medical record supports medical necessity that includes a diopter change of 0.5d or more in the sphere, cylinder, or prism measurements. A new 24 month benefit period for eyewear begins with the placement of the new nonprosthetic eyewear.
- Replacement of nonprosthetic eyeglasses or contact lenses because of loss or destruction is a benefit of Texas Medicaid for clients who are birth through 20 years of age. If the eyeglasses or contact lenses are lost or destroyed, the provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and the signed form must be maintained in the client's medical record.

- For clients who have had insertion of an intraocular lens (IOL), one pair of eyeglasses or contact lenses may be reimbursed. Additional eyeglasses or contact lenses may be considered when documentation in the client's medical record supports medical necessity that includes a diopter change of 0.5d or more in the sphere, cylinder, or prism measurements.

Note: *Because the IOL is considered the prosthetic device, the eyeglasses or contact lenses, and any replacements, are considered nonprosthetic.*

Refer to: Subsection 4.3.5.1, "Routine Vision Testing" in this handbook for information about vision testing for the purposes of prescribing eyewear.

The prescription for eyeglasses must be given to the client upon request. A provider may not withhold a prescription for eyeglasses from a client even if Medicaid reimbursement for the eye examination has not been received.

To be considered by Texas Medicaid, the eyeglasses or contact lenses must be:

- Medically necessary.
- Prescribed by a doctor of medicine, optometry, or osteopathy.
- Prescribed to significantly improve vision or correct a medical condition.
- In compliance with eyeglass program specifications for frames and lenses as stated in TAC Rule 354.1017, Specifications for Eyewear and Rule 363.503, Specifications for Eyewear.

4.3.6.1 Eyeglass Lenses and Frames

The following eyeglass lens procedure codes may be billed with frame procedure codes V2020 and V2025 for reimbursement of a pair of eyeglasses:

Procedure Codes									
Single Vision Lenses									
V2100	V2101	V2102	V2103	V2104	V2105	V2106	V2107	V2108	V2109
V2110	V2111	V2112	V2113	V2114	V2115	V2118	V2121		
Bifocal Lenses									
V2200	V2201	V2202	V2203	V2204	V2205	V2206	V2207	V2208	V2209
V2210	V2211	V2212	V2213	V2214	V2215	V2218	V2219	V2220	V2221
Trifocal Lenses									
V2300	V2301	V2302	V2303	V2304	V2305	V2306	V2307	V2308	V2309
V2310	V2311	V2312	V2313	V2314	V2315	V2318	V2319	V2320	V2321

For the purpose of Texas Medicaid, high-powered lenses are lenses with a sphere greater than 7.00d or a cylinder greater than 4.00d.

Providers must bill a quantity of two when billing for bilateral lenses with the same prescription.

The following procedure codes may be reimbursed for add-on services:

Add-On Procedure Codes									
V2410	V2430	V2700	V2710	V2715	V2718	V2730	V2755	V2770	V2780
V2784									

Add-on procedure codes will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

The fitting of eyeglasses (procedure codes 92340, 92341, 92342, and 92370) is considered part of the dispensing procedure and is not separately reimbursed.

Polycarbonate Lens
Procedure code V2784 for polycarbonate lens is considered an add-on procedure code. Polycarbonate lenses may be reimbursed for clients with one of the following medical or physical conditions that are a high risk for eye injuries due to eyewear breakage (this list is not all-inclusive):

- Cerebral palsy
- Multiple sclerosis
- Muscular dystrophy
- Epilepsy
- Autism
- Down syndrome
- Brain trauma
- Balance disorders
- Parkinson disease
- Seizure disorder
- Motor ataxia
- Marvin syndrome
- Ocular prostheses
- Amblyopia
- Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration
- Monocular vision with functional vision in one eye
- Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment)

Procedure code V2784 may be reimbursed when it is billed with one of the following diagnosis codes:

Diagnosis Codes									
29900	29901	29910	29911	29980	29981	29990	29991	30722	33182
33183	3320	3321	340	3430	3431	3432	3433	3434	3438
3439	34500	34501	34510	34511	3452	3453	34540	34541	34550
34551	34560	34561	34571	34580	34581	34590	34591	3590	3591
35921	35922	35923	35924	35929	3593	3594	3595	3596	35971
35979	35981	35989	3599	36101	36102	36103	36104	36105	36106
36107	36112	36113	36130	36131	36132	36133	36181	36189	3619
36800	36801	36802	36803	36970	36972	36973	36974	36975	36976
38600	38601	38602	38603	38604	38610	38611	38612	38619	38630
38631	38632	38633	38634	38635	38640	38641	38642	38643	38648
38650	38651	38652	38653	38654	38655	38656	38658	7580	75982
7670	85400	85401	85402	85403	85404	85405	85406	85410	85411

Diagnosis Codes								
85412	85413	85414	85415	85416	85419	99651	99653	99669

For the following instances, providers must submit documentation of medical necessity with the claim:

- For all diagnoses other than those in the diagnosis table above. If documentation is not submitted with the claim, the polycarbonate lenses will be denied.
- For lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens material due to weight, thickness, or aberration.

Undeliverable Eyeglasses
The provider may be reimbursed for the lenses based on the services furnished and the materials used up to the time the provider learned that the eyeglasses were undeliverable due to any of the following:

- The client cancels an order for eyeglasses prior to their completion and delivery.
- The prescription changes prior to completion and delivery of the eyeglasses.
- The client dies prior to completion and delivery of the eyeglasses.

Reimbursement will not be made for the frames.

4.3.6.2 Contact Lens and Corneal Bandage

The following procedure codes may be reimbursed for contact lenses:

Procedure Codes									
92326	V2500	V2501	V2502	V2510	V2511	V2512	V2513	V2520	V2521
V2522	V2523	V2530	V2531	V2599					

The following procedure codes may be reimbursed for the fitting or modification of a contact lens:

Procedure Codes									
92071	92072	92310	92311	92312	92313	92314	92315	92316	92317
92325									

Note: *Procedure codes 92071 and 92072 must be submitted with modifier LT or RT and will be denied if it is billed with the same date of service as procedure codes 92018 and 92019.*

Corneal Bandage
A soft corneal plano bandage lens may be medically necessary for eye protection to prevent blindness due to a disease process. Procedure codes 92071 and 92072 may be reimbursed for the fitting of the corneal bandage for treatment and management.

Corneal bandage may be reimbursed once per eye, per day when it is billed by any provider. Modifier LT or RT must be included on the claim to identify the eye on which the service was performed.

Prior Authorization Requirements
Nonprosthetic contact lenses and corneal plano bandage lenses must be prior authorized. The following documentation must be submitted with a request for nonprosthetic contact lenses and must be signed and dated by the prescribing physician or optometrist:

- Diagnosis causing the refractive error (such as keratoconus)
- Include the current and new prescriptions supporting a change of 0.5d or more in the sphere, cylinder, or prism measurements
- Indicate which eyes to be treated

- Specify the procedure codes requested
- Include a brief statement addressing the medical necessity for vision correction by contact lens(es) and specify why eyeglasses are inappropriate or contraindicated for this client

For the soft corneal plano bandage lens (procedure code 92071 or 92072), nonprosthetic contact lenses for nonemergency placement require prior authorization that must be obtained before the lenses are dispensed. Documentation submitted with the request must include the information listed above.

Nonprosthetic contact lenses for emergency placement do not require prior authorization. The emergency condition necessitating a corneal bandage must be documented on the claim.

Additional nonprosthetic contact lenses may be considered more frequently than the limitations outlined in this handbook when documentation in the client's medical record supports medical necessity for a diopter change of 0.5d or more in the sphere, cylinder, or prism measurements.

4.3.6.3 Dispensing Requirements

Providers must be able to dispense standard size frames at no cost to the eligible client. The following criteria must be met for the dispensed frames:

- Providers must offer each client who is 20 years of age or younger a choice of six styles in three colors for each type of frame: metal, zylonite, or combination of metal and zylonite.
- Providers must offer each client who is 21 years of age or older a choice of three styles in three colors for each type of frame: metal, zylonite, or combination of metal and zylonite.

When a client chooses eyeglass or contact lens options that are beyond program limitations, the client must acknowledge their choice and his or her liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form.

Dispensing of contact lenses include 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.

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of (1) fabricated and finished spectacle lenses, (2) frames, or (3) other ophthalmic devices, prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

4.3.6.4 Repair

The eyeglass supplier is required to perform minor repairs on request (without charge). Minor repairs are those that cost $2 or less. The minor repairs are included in the reimbursement for the eyeglasses and are not reimbursed separately.

For clients who are birth through 20 years of age, repairs that cost more than $2 may be reimbursed using procedure code V2799. The following criteria apply:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All repair supplies must be new and at least equivalent to the original item.
- The provider must maintain in the client's medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.

For clients who are 21 years of age and older, repair of nonprosthetic eyeglasses or contact lenses is not a benefit when the actual cost of materials exceeds $2.

The provider must make the client's medical record available for review upon request.

4.3.6.5 Replacement

Clients who are birth through 20 years of age may obtain replacement nonprosthetic eyeglasses if the first pair is lost or destroyed. There are no limitations on the number of replacements a client who is birth through 20 years of age may receive. If the eyewear is lost or destroyed, the provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form. Claims for replacement lenses must be submitted with the RB modifier to ensure accurate processing. Prior authorization is not required for the replacement of nonprosthetic eyeglasses.

Clients who are 20 years of age and younger may obtain replacements for nonprosthetic contact lenses if the first pair is lost or destroyed. Prior authorization is required for replacement of non-prosthetic contact lenses.

If the client is diagnosed with aphakia, procedure code 92326 may be reimbursed for the replacement of a contact lens. Procedure code 92326 may be reimbursed when it is billed with one of the following diagnosis codes:

Diagnosis Codes					
37931	37932	37933	37934	74335	V431

4.3.6.6 Medicare Coverage for Nonprosthetic Eyewear

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses because of refractive errors are not a benefit of Medicare. These services must be filed directly to Texas Medicaid when performed for a Medicare/Medicaid client. Medicare coverage is limited to eye examinations for treatment of eye disease or injury and for a diagnosis of aphakia. When performing an eye examination with refraction for a Medicare/Medicaid client diagnosed with aphakia or disease or injury to the eye, the following procedures must be followed:

- Procedure code 92015 must be used to bill Texas Medicaid for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only.
- The medical portion of the eye examination (procedure code 92002, 92004, 92012, or 92014) is covered by Medicare and must be billed to Medicare first. Medicare forwards this portion of the examination automatically to TMHP for payment of coinsurance or deductible.

Important: *Providers performing eye exams for refractive errors on Medicaid Qualified Medicare Beneficiary (MQMB) clients must bill TMHP. Do not send the refraction (procedure code 92015) to Medicare first. Texas Medicaid will not waive the 95-day filing deadline if the claim is billed to Medicare in error, nor will Medicare transfer the refraction to Texas Medicaid for payment.*

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an IOL. Medicare considers the IOL the prosthetic device. Texas Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Texas Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the procedure codes in subsection 4.3.6, "Vision Services for Nonprosthetic Eyewear" in this handbook.

4.3.7 Vision Services for Prosthetic Eyewear

Definition: Prosthetic eyeglasses or contact lenses are lenses that replace the eye's organic lens when it is absent due to congenital or acquired aphakia. Aphakia may be the result of a congenital abnormality or defect or an acquired condition as a result of trauma or cataract removal.

Limitations: Prosthetic eyeglasses or contact lenses may be provided based on medical necessity. Eye examinations and prosthetic eyewear may be reimbursed as follows:

- Eye examinations for aphakia (including congenital aphakia) and disease or injury to the eye may be reimbursed as often as is medically necessary.
- One pair of permanent prosthetic eyeglasses or contact lenses is a benefit during a client's lifetime.
- Replacement of prosthetic eyeglasses or contact lenses may be reimbursed for clients of any age due to loss or destruction of the eyewear or due to a significant change in visual acuity with a diopter change of 0.5d or more in the sphere, cylinder or prism measurements. The provider must maintain in the client's medical record documentation that supports the medical necessity for the replacement eyeglasses or contact lenses.

Prosthetic eyeglasses or contact lenses may be reimbursed when billed with modifier VP and one of the following aphakia diagnosis codes:

Diagnosis Codes					
37931	37932	37933	37934	74335	V431

Refer to: Subsection 4.3.6, "Vision Services for Nonprosthetic Eyewear" in this handbook for the eyeglass lens, frame, and contact lens procedure codes and dispensing requirements that apply to prosthetic and nonprosthetic eyewear.

Prior authorization is not required for prosthetic eyeglasses or contact lenses.

The date of cataract surgery is not required on the claim for permanent prosthetic eyeglasses.

4.3.7.1 Temporary Eyeglasses or Contact Lenses

Temporary prosthetic eyeglasses or contact lenses after cataract surgery may be reimbursed when it is billed with the appropriate lens and frame procedure codes and diagnosis code V431.

Temporary prosthetic eyeglasses may be reimbursed for up to 4 months after surgery until the client is ready for permanent prosthetic lenses. The date of surgery is used to determine the convalescence period for temporary prosthetic eyeglasses. Temporary lenses will be denied if they are dispensed more than 4 months after the date of surgery.

Temporary prosthetic lenses may be reimbursed as often as is medically necessary during the postsurgical convalescence period.

4.3.7.2 Contact Lens Fitting and Modification for Prosthetic Use

The following procedure codes may be reimbursed for prosthetic contact lenses fitting:

Procedure Codes									
92071	92072	92310	92311	92312	92313	92314	92315	92316	92317
92325									

Fitting services are included in the reimbursement for prosthetic eyeglasses or contact lenses.

Prior authorization for a prosthetic contact lens is not required.

4.3.7.3 Repair

The eyeglass supplier is required to perform minor repairs on request (without charge). Minor repairs are those that cost $2 or less. The minor repairs are included in the reimbursement for the eyeglasses and are not reimbursed separately.

For clients who are birth through 20 years of age, repairs that cost more than $2 may be reimbursed using procedure code V2799. The following criteria apply:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All repair supplies must be new and at least equivalent to the original item.
- The provider must maintain in the client's medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.

The provider must make the client's medical record available for review upon request.

4.3.7.4 Replacement

Replacement prosthetic eyeglasses or contact lenses may be reimbursed as often as is medically necessary if the replacement is due to loss, destruction, or a significant change in visual acuity.

The appropriate eyeglass and frame or contact lens procedure codes must be billed with modifier RB to indicate replacement.

Refer to: Subsection 4.3.6, "Vision Services for Nonprosthetic Eyewear" in this handbook for the eyeglass lens, frame, and contact lens procedure codes and dispensing requirements that apply to prosthetic and nonprosthetic eyewear.

Procedure code 92326 for the replacement of a contact lens may be reimbursed when it is billed with a diagnosis of aphakia:

Diagnosis Codes					
37931	37932	37933	37934	74335	V431

4.3.7.5 Intraocular Lens (IOL) and Additional Eyewear

Intraocular lenses are benefits of Texas Medicaid. If conventional eyewear is medically necessary in addition to the IOL, the IOL is considered the prosthetic device, and the eyewear and any replacements are considered nonprosthetic.

Refer to: Subsection 8.2.48.4, "Intraocular Lens (IOL)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about IOL benefits.

Subsection 4.3.6, "Vision Services for Nonprosthetic Eyewear" in this handbook for more information about nonprosthetic eyewear.

4.3.7.6 Artificial Eyes

For clients who are birth through 20 years of age, artificial eyes may be considered under CCP.

4.3.7.7 Ultraviolet (U-V) Protection

Procedure code V2755 may be reimbursed for U-V protection when it is billed with an aphakia diagnosis code (diagnosis code 37931, 37932, 37933, 37934, 74335, or V431).

UV lens procedure code V2755 will be denied when billed with the same date of service by the same provider as polycarbonate lens procedure code V2784.

UV and polycarbonate lens procedure codes are subject to CMS NCCI relationships.

Refer to: The CMS NCCI web page at www.cms.hhs.gov/NationalCorrectCodInitEd/ for the published correct coding guidelines and specific applicable code combinations.

4.3.8 Surgical Vision Services

Refer to: Subsection 8.2.39.13, "Fluocinolone Acetonide (Retisert)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about fluocinolone acetonide benefits.

Subsection 8.2.48, "Ophthalmology" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about surgical vision services.

4.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including vision services. Vision services are subject to retrospective review and recoupment if documentation does not support the service billed.

The client must sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form, and the provider must retain it in the provider's records.

When a client chooses an eyeglasses or contact lens option beyond the program limitations, or nonprosthetic eyeglasses or contact lenses are replaced because of loss or destruction the client must acknowledge their choice and liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records.

The current and previous prescriptions must be documented in the client's medical record.

The provider must make the client's medical record available for review upon request by the following:

- HHSC
- Office of the Attorney General
- TMHP

4.5 Claims Filing and Reimbursement

4.5.1 Claims Filing

Vision care service claims must be submitted to TMHP in an approved electronic format or on a 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. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

When submitting the client's old and new prescriptions to show a diopter change of .5 or more, enter the new prescription in Block 24D, line 5, and the old prescription in Block 24D, line 6 of the CMS-1500 paper claim form.

Claims for eye examination services require a diagnosis. If eyeglasses are not prescribed, diagnosis code V720 may be used. Diagnosis code V720 must not be used on claims for eyewear. If the diagnosis is not known by the supplier of the eyewear, diagnosis code 3689 is acceptable. Claims for eye examinations that lack a diagnosis are listed as an incomplete claim on the Remittance and Status (R&S) report and must be resubmitted for payment consideration. Electronic claims that lack a diagnosis will be rejected. A letter with the reason for rejection and instructions for resubmission will be mailed the following business day.

When the eye exam limitation is exceeded for clients who are 20 years of age and younger, identify one of the following situations in Block 19 of the CMS-1500 paper claim form:

- A school nurse, teacher, or parent requests the eye examination.
- The eye examination is medically necessary.

4.5.2 Reimbursement

Professional services by an optometrist for contact lenses and prosthetic eyewear are reimbursed in accordance with 1 TAC, §§355.8001, 355.8081, and 355.8085.

FQHCs are paid an all-inclusive rate per visit for payable services in accordance with 1 TAC, §355.8261.

Suppliers of nonprosthetic lenses and frames are reimbursed the lesser of their billed amount or of the established maximum allowable fee in accordance with 1 TAC, §355.8001. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Form VH.6, "Vision Services" in this handbook for a claim form example.

The nonsurgical vision procedure codes included in this handbook may be subject to the CMS NCCI relationships.

Refer to: The CMS website at www.cms.gov for more information about CCI relationships.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

4.5.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

If applicable and consistent with CMS billing guidelines, procedure codes must be billed with modifier LT (left side) or RT (right side) to identify the eye on which the service was performed.

5. CLAIMS RESOURCES

Refer to the following sections and forms when filing claims:

Resource	Location
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	TMHP Telephone and Address Guide (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Hearing Aid Assessments Claim Form Example	Form VH.5, Section 8 of this handbook
Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)	Form VH.1, Section 7 of this handbook
Physician's Examination Report	Form VH.2, Section 7 of this handbook
Appendix A: State and Federal Offices Communication Guide	Appendix A (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
Vision Care Eyeglass Patient (Medicaid Client) Certification Form	Form VH.3, Section 7 of this handbook
Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)	Form VH.4, Section 7 of this handbook
Vision Services Claim Form Example	Form VH.6, Section 8 of this handbook

6. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

7. FORMS

VH.1 Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)

Name (Last, First, Middle Initial)		Client No.	Age	Birth Date
Address (Street, City, State, ZIP Code)				
Date of Examination	Place of Examination	Puretone Audiometry: ANSI 2004 ❑ Yes ❑ No		
Date of Audiometer Calibration	Ambient Noise** _____dBa_____dBc	**Ambient noise level measurements MUST be made at the time of EACH evaluation not conducted in a commercial sound treated test booth. Testing must follow the ambient noise guidelines as stated in the provider's licensure rules.		

Indicate with an asterisk (*) by Recorded Threshold when masking is used

PURETONE TEST RESULT IN DECIBELS
(Completed by physicians and audiologist only)

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

BONE CONDUCTION

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

SPEECH AUDIOMETRY

	SRT	PB Quiet	PB Level	Thres. Disc.
LE				
RE				
Masking Level LE				
Masking Level RE				

FITTING AND DISPENSING RESULTS

Results are _____Real ear measurement in Sound Pressure Level (SPL)
_____Soundfield Function gain in decibels (dB)
Acquisition Cost: Left aid:_____ Right aid:_____

Fill in results below for ear(s) fitted:

Manufacturer:			Model		
	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz
Left ear aided					
Right ear aided					

Comments:

Is report of Physician's Examination attached? ❑ Yes ❑ No

FITTER AND DISPENSER: The fitter and dispenser must sign below.

_____
Name of Fitter and Dispenser (please type or print)

_____
Signature – Fitter and Dispenser Date

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

I, _____ do hereby certify that I am _____ and that
(Signature of Physician or Audiologist) (Title of Person Certifying)

I am duly authorized to make this certification for and on behalf of _____
(Name of Payee Company Claimant)

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct and unpaid.

_____
(Signature of Physician or Audiologist) Date

_____

Effective date December 2, 2008 Revision date December 2, 2008

VH.2 Physician's Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, ZIP Code)		

1. Date Of Examination*

2. Ear Examination:

a. Within Normal Limits ❑ Yes ❑ No

b. Cerumen Removed ❑ Yes ❑ No

c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ❑ Yes ❑ No

If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? ❑ Yes ❑ No

If yes, a hearing aid is medically prohibited in ❑ Right Ear ❑ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ❑ Yes ❑ No

Signature* - Physician	Physician's Name (please type or print)	Medical Specialty
Address		Telephone No.

***NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM**

To be reimbursed for the examination, you must submit this completed form along with a claim for physician's services to the following address:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Suite 150
Austin, TX 78727

VH.3 Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, _____ , certify that:

Printed name of Medicaid client

(Check all that apply:)

☐ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. *I will be responsible for any balance for eyewear beyond Medicaid program benefits.*

My selection(s) beyond Medicaid benefits were:

1. _____
2. _____
3. _____
4. _____

☐ The glasses that are being replaced were unintentionally lost or destroyed.

☐ I picked up/received the eyewear.

_____ _____

Medicaid client signature Witness signature

_____ _____

Date Date

_____

Client Medicaid number

_____

Provider TPI

_____

Provider NPI

Effective Date_01152008/Revised Date_08072007

VH.4 Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)

Yo, _____ , declaro que:
Nombre del cliente de Medicaid

(Marque todos los que apliquen)

☐ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. *Yo entiendo que tendré que pagar por la diferencia.*

La selección(es) de lentes que escogí fue:

1. _____
2. _____
3. _____
4. _____

☐ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionadamente.

☐ Yo recibí los lentes.

_____ _____
Firma del Cliente Firma de Testigos

_____ _____
Fecha Fecha

_____
Número de identificación de Medicaid del Cliente

_____
Número de identificación del proveedor (TPI)

_____
Número de identificación del proveedor (NPI)

Effective Date_01152008/Revised Date_08082007

8. CLAIM FORM EXAMPLES

VH.5 Hearing Aid Assessments

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) x TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane K.	3. PATIENT'S BIRTH DATE MM 10 DD 26 YY 2000 SEX M F x	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 460 Jennings Lane	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY: Palestine STATE: TX	8. PATIENT STATUS: Single Married Other	CITY STATE
ZIP CODE: 75801 TELEPHONE (Include Area Code): (409) 555-1234	Employed Full-Time Student Part-Time Student	ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES x NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES x NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES x NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? x YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 389.9 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2012 01 01 2012	1		92551		1	62.12	1		NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 123456	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) x YES NO	28. TOTAL CHARGE: $ 62.12
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Tom White SIGNED 01 10 2012 DATE	a. NPI b.	The Hearing Aid Store/Service Ctr. 432 New Pines Palestine, TX 75801 a. 9876543021 b. 1234567-01

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

VH.6 Vision Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ( ) (Medicare #) MEDICAID (X) (Medicaid #) TRICARE CHAMPUS ( ) (Sponsor's SSN) CHAMPVA ( ) (Member ID#) GROUP HEALTH PLAN ( ) (SSN or ID) FECA BLK LUNG ( ) (SSN) OTHER ( ) (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 512345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane	3. PATIENT'S BIRTH DATE MM DD YY: 01 01 2001 SEX M ( ) F (X)
	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1234 N. Main Street	6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )
	7. INSURED'S ADDRESS (No., Street)
CITY: Anytown STATE: TX	8. PATIENT STATUS: Single ( ) Married ( ) Other ( )
	CITY STATE
ZIP CODE: 77123 TELEPHONE (Include Area Code): (123) 555-1234	Employed ( ) Full-Time Student ( ) Part-Time Student ( )
	ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John	10. IS PATIENT'S CONDITION RELATED TO:
	11. INSURED'S POLICY GROUP OR FECA NUMBER: 412345678A
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789	a. EMPLOYMENT? (Current or Previous) YES ( ) NO (X)
	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )
b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 05 01 1966 SEX M (X) F ( )	b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)
	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME: ABCD, Inc. Prudential	c. OTHER ACCIDENT? YES ( ) NO (X)
	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on File

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY: 05 01 2012 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Dan Smith	17a. 17b. NPI 8819004002
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 367.1 2. 367.9 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 01 2012	05 01 2012	1		V2020		1, 2	175.00			NPI	
2 05 01 2012	05 01 2012	1		V2100		1,2	10.00			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN ( )	26. PATIENT'S ACCOUNT NO.: 123456	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES (X) NO ( )	28. TOTAL CHARGE: $ 175.00	29. AMOUNT PAID: $ 20.00	30. BALANCE DUE: $ 155.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Dr. Dan Smith, MD 05 01 2012 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Eyecare Clinic 124 S. First Street Anytown, TX 77123 a. NPI b.		33. BILLING PROVIDER INFO & PH #: (111)222-3333 Dr. Dan Smith, M.D. 1234 S. First Street Anytown, TX 77123 a. 1234567089 b. 1234567-01		

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