Avēsis / CountyCare Health Plan Medicaid
Routine Vision Services Plan Sheet - Optometrist

Service	Benefit / Service Code		Avēsis Pays	Enrollee Pays
ANNUAL ROUTINE EYE EXAMINATION All Enrollees	92002 / 92004 92012 / 92014 92015		$29.19/ $60.43 $32.23/ $48.56 $18.45	$0.00
Materials for All Enrollees				
AVĒSIS CONTRACTED LAB MATERIALS	Frame Kit Dispensing Fees Replace & Refit	92340 / 92341 92370	$30.09 $4.63	$0.00
PROVIDER FABRICATED MATERIALS	**Within Selection:**			
	Frames	V2020	$9.11	$0.00
	Lenses	V2100-V2114 / V2115 / V2121 V2200-V2214 / V2215 / V2221 V2784/per pair	$6.50 $8.00 $6.26	$0.00
	Out of Selection:			
	Frames	V2025 up to $125 retail value	$30.00	Amount exceeding $125
	Lenses	V2100-V2114 / V2115 / V2121 V2200-V2214 / V2215 / V2221 V2784/per pair	$6.50 $8.00 $6.26	$0.00
	Dispensing Fees Replace & Refit	92340 / 92341 92370	$30.09 $4.63	$0.00
OR				
Elective Contact Lenses *In lieu of eyeglasses and replacement eyeglasses*	Fitting Fee	92310	$50.00	$0.00
	Contact Lenses	V2523	Up to $300.00	Amount exceeding $300
Medically Necessary Contact Lenses				
MEDICALLY NECESSARY CONTACT LENSES All Enrollees	**Prior Authorization required – Avēsis Clinical Protocols Will Apply** *Medically Necessary Contact Lenses require prior approval, except when provided to children age 0 to 3 who have aphakia. Refer to Provider Manual for benefit details.			
	MNCL Fitting	92071 – Ocular surface disease fitting 92072 - Keratoconus fitting	$50.00 $100.00	$0.00
	Contact Lenses	V2500 / V2510 / V2520 V2531 / V2599	$18.97 Invoice Cost	

Diabetic Enrollees: Providers are *required* to submit the appropriate CPT Category II Service Codes when providing professional services to enrollees diagnosed as diabetic (2022F, 2023F, 2024F, 2025F, 2026F, 3051F, 3052F, 3072F).

Benefit Frequency

- Exam: 1 exam every calendar year.
- Frame/Lens/Elective Contact Lenses:
  - 1 pair available every calendar year for all enrollees.
  - However, the limitation does not apply to an individual who needs different eyeglasses following a surgical procedure such as cataract surgery (providers must submit a prior approval request for an adult in these circumstances).

Replacement Frames and Lenses

- For children through age 20, eyeglasses are replaced every calendar year as medically necessary and appropriate, with no prior approval required; documentation of new eyeglass orders must be maintained in the provider file.
- For adults 21 years of age and older are limited to 1 replacement pair of eyeglasses every calendar year due to irreparable wear or damage, breakage, or loss No prior authorization is required.

Elective Contact Lenses

Elective contact lenses are covered in lieu of eyeglasses, for up to $300 every calendar year with no replacement option. Any amount exceeding $300 for the contact lenses is the enrollee's responsibility.

Medically Necessary Contact Lenses (All Enrollees) Enrollee must be provided:

- Contact lens and required care kits
- Instructions on insertion, removal, and proper care of the lenses
- A 90-day follow-up visit period that includes acuities, assessment of corneal physiology, biomicroscopy examination, and other procedures required (as necessary)

Assignment
The Provider must accept an Assignment of Benefits for all eligible enrollees. The enrollee's signature is required on the Assignment of Benefits clause. The claim form authorizing payment can be submitted online at www.avesis.com or a CMS-1500 form can be mailed to: Avēsis Third Party Administrators, LLC, P.O. Box 38300, Phoenix, AZ 85069-8300. Please direct questions regarding eligibility to 866-337-1596.

Frame Requirement
- Each frame dispensed must carry a minimum of a one (1) year manufacturer's warranty.
- Minor adjustments are to be provided for a period of one (1) year at no additional charge

Eyeglass Lens Requirement
- CR39 or glass lenses are a covered benefit for all enrollees
- Lenses must meet the requirements of inspection, tolerance, and testing procedures as outlined in the American Standard Prescription Requirements and the current Food and Drug Administration (FDA) standards of impact resistance
- Single vision lenses are covered only if the power is at least ± 0.75 diopters, in either the sphere **or** cylinder component; a change of lenses is a covered service only when there is a change of at least ± 0.75 diopters, in either the sphere **or** cylinder component
- Bifocal lenses are covered only if the power of the bifocal addition is ± 1.00 diopter or more; a change in lenses is covered if the distance power meets the minimum change requirements (± 0.75 diopters), or if the power of the bifocal addition is changed by at least ± 0.50 diopters
- When changing from a single vision to bifocal, the distance component must meet the minimum prescription requirement (± 0.75 diopters), or the resultant total power of the new prescription must meet the requirement for a change in prescription (± 0.75 diopters)
- When changing from bifocal to single vision, the new prescription must meet the requirement for a change in prescription (± 0.75 diopters) figured from the resultant total power of the bifocal prescription, **and** the new prescription must meet the minimum prescription power requirement (± 0.75 diopters)
- Prisms meeting the minimum power requirements do not require prior approval; the requirements are met only when the combined vertical prism power is at least ± 2 prism diopters, or the combined horizontal prism power is at least ± 5 prism diopters; V2715 at $2.71 per eye.
- Polycarbonate eyeglass lenses:
  - All children through age 20, no prior authorization required
  - Adults age 21 and over, with prior approval and a prescription of ± 2.50
- Hi index lenses are covered when the power is at least ± 12 diopters; V2782 at $29.64 per pair / V2783 at $36.41 per pair
- Polarized lenses are covered if the prescription criterion for regular single vision or regular bifocal lenses is met in addition to one of the following: Chronic iritis, Uveitis or other active inflammatory eye disease with fixed and dilated pupils or Aniridia; V2744 at $22.59 per pair without prior authorization / V2762 requires prior authorization and invoice with claim; reimbursement is invoice cost + 50%.
- V2600 requires prior authorization and must include information explaining in detail the patient's need for the device. Convenience items will not be covered. Duplicate items will not be covered in the same benefit cycle. The invoice is required with claim submission as the reimbursement is invoice cost + 50%.

Non-Covered Frame and Lenses
- Sunglasses and cosmetic lenses
- Replacement lenses without significant change in refractive error
- Trifocal, blended or progressive multi-focal lenses
- Low vision aids except V2600
- Necessary contact lens replacement
- Slab off
- Miraflex frames
- Transition lenses

IMPORTANT INFORMATION
Items Not Otherwise Identified: Services or materials that are not identified on the Optometric or Practitioner Fee Schedules require prior approval. Information must be submitted describing in detail the material or service to be provided. A history of past treatment provided is required. Additionally, the request for approval must show why the material or service is better than any other commonly used to deal with similar diagnoses or conditions. All items or services requested must be medically necessary.

AVĒSIS BILLING TIPS
Providers should report ALL applicable diagnosis codes to Avēsis in section 21 of the CMS-1500 claims form and online. The diagnostic pointer in section 24E of the CMS-1500 claim form and online must be limited to those diagnosis codes specific to the procedure code billed per line item in section 24 of the CMS-1500 claim form or online.

Additional information regarding this program can be found in the Avēsis Cook County Illinois CountyCare Medicaid Provider Manual or online at www.avesis.com