2024 Manual

Vision and Ocular

BlueCross BlueShield Kansas

bcbsks.com

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Important Contact Information

Customer Service Center (CSC)
- Email: csc@bcbsks.com
- Phone: 800-432-3990 or 785-291-4180
- Fax (written inquiries and predets): 785-290-0711
- Fax (all others): 785-290-0783

CSC Providers only benefits line
- Email: csc@bcbsks.com
- Phone: 800-432-0272 or 785-291-4183

Provider network services
- Email: prof.relations@bcbsks.com
- Phone: 800-432-3587 or 785-291-4135
- Fax: 785-290-0734

Availity® Essentials
- Phone: 800-Availity (800-282-4548)
- Log into Availity Essentials to submit a support ticket

BlueCard®
- Phone (eligibility for out-of-state members): 800-676-BLUE (800-676-2583)
- Phone (claim information for out-of-state members): 800-432-3990, ext. 4058

Case management
- Phone: 800-432-0216, ext 6628 or 785-291-6628
- For FEP members: 800-782-4437, ext. 6611

MiResource
- Email: support@miresource.com

Lucet
- Phone: 800-952-5906
- Fax: 816-237-2364

Medicare Advantage
- Provider Services: 800-240-0577 Fax: 800-976-2794
- Prior Authorization/Utilization Management/Care Transition:
- 800-325-6201 Fax: 877-218-9089
- After Hours Utilization Management/Care Transition: 800-331-0192 Fax: 877-218-9089
- Behavioral Health Services (Lucet): 877-589-1635
- Hearing Services: 800-334-1807
- Vision Services: 877-226-1115

Federal Employee Program (FEP) – all FEP inquiries except OPL
- Phone: 800-432-0379 or 785-291-4181
- Fax: 785-290-0764
- FEP Blue dental phone: 855-504-2583
- FEP Blue dental website: www.bcbsfepdental.com

Electronic Data Interchange (ASK-EDI) – Payor ID: 47163
- Email: askedi@ask-edi.com
- Phone: 800-472-6481 or 785-291-4178
- Fax: 785-290-0720
- Website: ask-edi.com

Fraud hotline
- Phone: 800-432-0216, ext. 6400 or 785-291-7000, ext. 6400

Other Party Liability (OPL) & Pre-Existing
- Phone: 800-430-1274 or 785-291-4013
- Fax: 785-290-0771

Pre-certification, concurrent review and alternate care
- Phone: 800-782-4437

Teleorder
- Phone: 800-346-2227 or 785-291-8130

BCBSKS address
- Location: 1133 SW Topeka Blvd, Topeka, KS 66629-0001

Billing: PO Box 239, Topeka, KS 66601-0239

Coverage Clarification

I. Non-Covered vs. Not Medically Necessary vs. Experimental or Investigational

Non-covered services/supplies are services/supplies in which benefits are not provided under the member's contract. Non-covered services are the patient's financial responsibility. The contracting provider may collect for these services, in full, at the time they are rendered and/or supplied.

Not medically necessary services are for health care services or supplies that do not meet medical policy requirements and/or do not meet accepted standards of medicine needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms. BCBSKS considers these services to be a provider write-off unless a "Limited Patient Waiver" (waiver) is signed prior to the service being provided.

Experimental or investigational services are services, equipment, facility, or supply (including drugs or drug usage) that has not been proven effective to the point that it has been accepted as standard medical practice by the general medical community, and/or does not have federal approval. BCBSKS considers these services a provider write-off unless a waiver is signed prior to the service being rendered.

Non-covered services should not be confused with services that are determined to be not medically necessary, experimental, or investigational.

When filing claims for services considered not medically necessary or experimental/investigational and the patient has signed a waiver prior to services being rendered, report modifier "GA" on the appropriate line item to indicate a waiver is on file. The service will then become member responsibility instead of a provider write-off. Waivers must be patient, date of service, reason deemed not medically necessary, service, and amount specific in order to be considered valid. Filing a claim with a copy of the waiver is not necessary. However, a copy of the waiver should be kept in the patient file and made available upon request.

Note: A waiver cannot be used to collect the difference between the provider's charge and the allowed amount on a given covered service, nor can it be used for services that are content to another service provided. However, if the member requests a deluxe item or requests higher end services that may be otherwise covered at a basic level, a waiver can be used to collect the difference between the allowance for the basic service and the charge. An example of a waiver can be found in Policy Memo No. 1, page 30.

Eye Examinations

I. Eye Examinations

All eye exams are subject to member benefits.

II. Accident/Medical Emergency Diagnosis on Claim Form

An accident/medical emergency diagnosis must be submitted as the primary diagnosis in loop 2300 HI01-2 electronically or in the first position in Box 21 of the CMS 1500 claim form.

If Box 10 a, b, **or** c, is marked "yes" another date related to the patient's condition or treatment is needed. Enter the date in a six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format. If Box 10a, b, **or** c are marked "yes," Qualifier 439 must be reported in box 15 along with the date of the accident. (Loop 2300, DTP01 for qualifier and Loop 2300 DTP03 for date of accident for electronic claims).

III. Refraction 92015

- Refraction may be billed and reimbursed concurrently with an examination when the exam/refraction is provided for a medical condition.

  NOTE – For Federal Employee Program (FEP), if the 92015 is billed with a routine diagnosis, it will deny as non-covered (patient responsibility).
- If a refraction (92015) is billed with an eye exam in absence of a medical condition/diagnosis, it will deny Content of Service to the exam.
- **A Waiver cannot be utilized for services considered to be content of another service provided. More information can be found in Policy Memo 1, X.**
- Billing an exam with disorders of refraction and accommodation or a preventive diagnosis on the same date of service as a medical diagnosis for a refraction is not a typical scenario. This billing practice may be an audit red flag

IV. Content of Service

The following services are considered part of the eye exam and should not be billed separately:

- Preparation of patient record with routine demographic information.
- Analysis of power of present glasses, if any (manual or computerized automatic lens analyzer).
- Case history of symptoms, past medical/ dental history, present medications and familial eye/vision problems, etc.
- Visual acuity testing at 20’ (Snellen chart) and 14” to 16” (Near-point Snellen card), both unaided and present glasses, if any.
- Color vision testing with color plates, either monocularly or binocularly (Ishara Color Vision Plates).
- Tonometry, either by Schiotz indentation, MacKay-Marg Electronic Applanation, Goldmann Applanation or non-contact methods (tonometer).
- Objective measurement of static (distance) refractive error by either retinoscopy or computerized autorefractor (retinoscopy or autorefractor).
- Blood pressure screening (sphygmomanometer).
- Cover test for gross muscle imbalances (occluder).
- Analysis of eye muscle movements, tracking and convergence (penlight).
- External ocular examination of lids and adnexae (penlight).
- Biomicroscopy of anterior segment-lid margins, corneas, iris, conjunctiva, estimation of anterior chamber depth, lens clarity, shallow vitreous (biomicroscope).
- Ophthalmoscopy, direct or indirect, from posterior poles, optic discs, maculas, and peripheral retinas (direct or indirect ophthalmoscope).
- Subjective refraction for correction of distance and near-refractive errors (phoroptor or trial lens set).
- Subjective coordination of testing for measurement of lateral or vertical imbalances as well as near-focusing ability (phoroptor, trial lens set and/or phorometer).
- External ocular photography
- Screening for defects in central and/or peripheral field of vision (arc perimeter, tangent screen or computerized auto field analyzer).
- Ophthalmometry for measuring corneal curvature and for presence of scarring and/ or keratoconus (ophthalmometer).

- Analysis of findings, consultation, determination of course of treatment and writing of prescription.
- Routine corneal topography.
- A Waiver cannot be utilized for services considered to be content of another service provided. More information can be found in Policy Memo 1, X

Hardware Coverage and Dispensing

I. Coverage

Most patients' contracts only cover lenses, frames or contact lenses when there has been cataract surgery or other medical conditions.

Vision Correction: *Lenses, Frames, and Contacts*

- Use appropriate HCPC code and nomenclature listing for all claims.
- HCPC V2781 requires indication between bifocals or trifocals by reporting appropriate HCPC code for the lenses.
- When billing two lenses, use the appropriate code as one line item and indicate two units.
- Slab off prism: HCPC V2710 can be considered for separate reimbursement. When billing for a bilateral procedure, bill two line items with one unit each and an RT or LT modifier on each line.

Contact Lens Guidelines

Contact lens coverage is subject to member benefits. If there is no vision hardware coverage, these services are considered non-covered and patient responsibility.

When there is no coverage, it is unnecessary to bill the contact exam, testing, fitting, and/or follow-up visits to Blue Cross and Blue Shield of Kansas (BCBSKS) unless the provider wants the service to deny for the purpose of notifying the patient. The patient may be billed at the time of service for the contact exam, testing, fitting, and/or follow-up visits.

If coverage exists, reimbursement for contacts is per box and not per lens.

Contact Lens for Medical Conditions

Contracts that exclude benefits for contact lenses related to vision correction may provide benefits for the treatment of a medical condition.

Fitting and supply of contacts:

- If billing for a contact lens fitting and lenses are not dispensed, providers should code claims with 92310-92326. BCBSKS does not include the reimbursement for lenses in these procedure codes.
- If billing for a contact lens fitting and lenses are dispensed, providers should code claims with 92310 for the professional portion and the proper V code for the lenses dispensed.

- Use 92071 for the fitting of the bandage lens. The cost of code 99070 (bandage lens) is included in the reimbursement of service when billed with 92071.
- Use code 92326 for the fitting of a replacement lens.
- Use the appropriate V code for non-disposable contacts.

II. Disposable Contacts

S0500 should only be used for disposable contacts, in box 24D of the CMS 1500 claim form or electronically in loop and segment 2400 and SV101-1. Indicate the number of boxes being dispensed as units for the service, using a three-digit number (two boxes should be reported as 002; one box should be reported as 001).

The claim should indicate the number of days, weeks, or months supply in box 24G of the 1500 claim form or electronically in loop and segment 2400 and SV103.

Reimbursement for contacts is per box and not per lens.

III. Date of Service

When dispensing frames and/or lenses, the date of service must be the date the items were dispensed, not the date they were ordered.

IV. Deluxe Services

Deluxe services should be billed as follows:

- Bill one line for the standard frame or lens (example: V2020) with your standard fee
- Bill one line for the deluxe frame or lens (example: V2025) with the difference between your standard option and the deluxe option
- A waiver for the deluxe service must be signed by the member prior to services being rendered. If a waiver is on file, any amounts over the MAP for a standard frame/lens will not be covered and will be the patient’s responsibility.
- GA is added to line #2 indicating a valid waiver is on file for the "deluxe" item
- Records are required, so the claim will need to be submitted via paper with attached information including cost, description of deluxe item, invoice, etc.

V. Charges Considered Content of Service

- Shipping and handling
- Taxes
- Fitting/Measuring
- Other dispensing services

Additional Guidelines

I. Avastin Coding

When billing ophthalmic Avastin, report the appropriate HCPC code (e.g. J3490: unclassified drug or J3590: unclassified biologic).

For paper claims, report the name of the drug, dosage, and NDC# in box 19 of the 1500 form.

Electronic claims, require the following information:

- Report qualifier "N4" in 2410 LIN02
- Report NDC# in 2410 LIN03
- Report dosage (National Drug Unit Count) in 2410 CTP04
- Units of measure ((UN=Unit, ml=, me=milligram, G= gram, F2=international unit) in 2410 CTP05-1
- Report "ADD" in 2400 NTE01
- Report name of drug in 2400 NTE02

II. Glaucoma Screening

- **G0117 —** Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist.
- **G0117** is considered content of the eye exam if performed on the same date.
- **If G0117** is performed by itself, it will be allowed based on patient benefits.

III. Pachymetry

Pachymetry generally is medically necessary once in a lifetime. See medical policy at the BCBSKS website.

IV. Fundus Photography

For coverage guidelines for Fundus Photography (CPT code 92250), see medical policy at the BCBSKS website.

V. External Photos

CPT code 92285 is considered content of service.

VI. Visual Fields

- **Confrontational Visual Fields** are considered content of service of an eye exam and should not be billed separately.
- **Visual Fields codes** (92081, 92082, 92083) are unilateral or bilateral, which means units of service should equal one.
- **Visual Field codes billed alone** (without exam) will be subject to member copay.

VII. Blepharoplasty and Blepharoptosis

Prior authorization is highly recommended. The Predetermination Request form can be found at the BCBSKS website.

VIII. Optical Coherence Tomography (OCT) of the Anterior Eye Segment

See medical policy at the BCBSKS website.

IX. Lasik

CPT codes 65760 and S0800 will be allowed for diagnosis of anisometropia.

X. Computerized Corneal Topography

See medical policy at the BCBSKS website.

XI. Photodynamic Therapy

This service should be coded with 67221 or 67225 plus the appropriate injection code. See medical policy at the BCBSKS website.

XII. Ophthalmic Diagnostic Imaging

CPT codes 92133 and 92134. See medical policy for Scanning Computerized Ophthalmic Diagnostic Imaging Devices at the BCBSKS website.

XIII. Cataract Surgery

Cataract surgery is a covered benefit. If the surgeon does not bill the global fee for the surgery, CPT modifiers 54, 55, and 56 need to be used. Billing guidelines are as follows:

- Use the appropriate procedure code for the surgery. If only providing surgical care, append the surgery code with modifier 54 — Surgical Care Only.
- Use modifier 55 — Postoperative Management Only with the procedure code for the surgery to indicate postoperative period being assumed. The Date Assumed/Relinquished Care is submitted in Loop 2300 DTP electronically or Box 19 of the CMS 1500 paper claim along with the actual number of days being billed for the postoperative care.
- Claims must show Date of Surgery submitted in loop 2300 DTP electronically or Box 24A of the CMS 1500 paper claim.
- Units should equal 1 submitted in loop 2400 SV104 electronically or Box 24G of the CMS 1500 paper claim.
- All claims related to cataract surgery need to have surgery date and the same surgery procedure code.
- When billing both 54 and 55 modifiers, each should be listed on separate line items. The surgeon must use modifier 54 with the same procedure code. If the surgeon does not, the claim will be denied as already paid to another provider. Date Assumed/ Relinquished Care is submitted in loop 2300 DTP electronically or Box 19 along with the actual number of days being billed for the postoperative care.
  If using 55 modifier, Box 15 must include Qualifier 090 with the date care was assumed.

Hardware Coverage After Cataract Surgery

Post-Cataract Surgery Diagnosis Codes

ICD-10		
H27.01	H27.03	Z96.1
H27.02	Q12.3	

- An initial pair of eyeglasses, frames, and lenses (or contact lenses) is reimbursed only when surgery for age related, congenital or traumatic cataracts has been performed to correct visual defects resulting from aphakia or pseudophakia.
- When cataract surgery is performed on only one eye, reimbursement still will be made on the frames but only on the lens for the eye on which the surgery was performed.

- Reimbursement is for standard lens allowance only. If member selects deluxe items, the standard lens allowance will be allowed and the balance will be patient responsibility
- SOK Members: There will be no coverage for hardware or contact lenses (with the exception of *intraocular lenses) under medical regardless of the medical diagnosis.

  *Reimbursement is only allowed for a standard intraocular lens. If a deluxe intraocular lens (e.g., Restor) is selected, any amounts over the MAP for a standard lens will not be covered and will be the patient's responsibility. A waiver for the deluxe service must be signed by the member prior to services being rendered. If a waiver is on file, any amounts over the MAP for a standard lens will not be covered and will be the patient's responsibility.
- See page 11 for deluxe services billing instruction.

Pediatric Vision Coverage under ACA Products

Annual eye exams are an important part of anyone's overall health routine, and they play a key role in ensuring a child's vision and academic development. BlueCare plans include pediatric vision coverage for those important exams, eyeglasses and other benefits.

Vision services are subject to deductible, coinsurance, or annual out-of-pocket maximum.

Below is a summary of the pediatric vision services offered to members up to age 19:

I. Eye Exams

- **Basic exams** are covered as needed when provided by ophthalmologists and optometrists.
- **Two exams** per month to detect and/or follow medical conditions.
- **As needed** up to one year following cataract surgery.

II. Eyeglasses (standard frames)

- **Frames** must include a one-year warranty.
- **Up to three** pairs of frames per 365 days.
- **One pair** of frames and lenses per date of service.
- **Up to three** sets of lenses per 365 days.
- **V2782 and V2783** can only be billed for plans with Pediatric Vision coverage for member up to age 19. All other policies will deny as non-covered.
- **Eyeglasses** provided for post-cataract surgery within one year of surgery.
- **Only standard** frames are covered. If a deluxe frame is requested by the patient, the member should sign a Limited Patient Waiver and mark Deluxe Service. If a waiver is on file, any amounts over the MAP for a standard frame will not be covered and will be the patient's responsibility.
- **Deluxe billing** service instructions can be found on page 11.

III. Contact Lenses

Contact lenses require prior authorization. Contact lens fitting is allowed once per lifetime when contacts are first prescribed and fitted. Subsequent fittings will be considered if a new type of

contact lens is being prescribed and fitted. Contact lenses and replacements are covered for monocular aphakia and bullous keratopathy.

IV. Blepharoplasty and Blepharoptosis

Surgery for the correction of eyelid defects requires prior authorization. The Predetermination Request form can be found at the BCBSKS website.

V. Exclusions

Although this is not a complete list, pediatric vision coverage excludes items such as LASIK surgery, sunglasses, safety glasses, athletic glasses, backup eyeglasses and contact lenses for cosmetic purposes. Pediatric vision coverage excludes sunglasses, transitional lenses, tints (including photochromatic), progressive lenses, safety glasses, athletic glasses, backup eyeglasses, polycarbonate lenses for convenience or cosmetic reasons, contact lenses for athletic participation, contact sunglasses, colored or tinted of any kind, contact lenses for cosmetic purposes and eyeglass fitting fees.

Claims Filing Guidelines

I. Left and Right Eyes

Modifiers RT for right eye, LT for left eye or 50 (bilateral) can be used to identify the specific eye(s) treated. For example:

Modifiers	Units
50	001
RT LT	002
RT	001
LT	001

II. Left, Right, Upper, and Lower Eyelids

To identify the specific eyelid treated, use one of the following modifiers after the procedure code:

- E1 for left upper
- E2 for left lower
- E3 for right upper
- E4 for right lower

III. Waiver of Liability

BCBSKS offers a form called Limited Patient Waiver that should be used for situations involving medical necessity denials, utilization denials, patient demanded services, deluxe services, and procedures BCBSKS considers to be experimental/investigational.

When a provider is aware or suspects that a service may fall under one of those categories, a conversation is expected to occur before the provision of the service. This gives the patient the option of determining if they want to assume the financial responsibility for the service.

Once the waiver is signed by the patient, the document becomes a part of their medical record. The provider can then communicate this process by adding modifier GA to the specific procedure code for which the waiver was obtained.

IV. Documentation Requirements/Medical Records

A. Form of documentation in medical records – Documentation in the medical record must accurately reflect the health care services rendered to the patient and is an integral part of the reimbursement, audit, and review processes.

1. Documentation of Medical Services – Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Each diagnosis submitted on the claim must be supported by the documentation in the patient's medical record. The contracting provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s) which shall be made available for audit and review at no charge.

   Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.
2. Cloned Medical Record Documentation – BCBSKS expects providers to submit documentation specific to the patient and specific to the individual encounter. Documentation should support the individualized care each BCBSKS member received.

   Documentation identified as cloned, copied and pasted, pulled forward, or inserted via template without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining services provided for that visit.
3. BCBSKS has adopted the following standards for documentation of medical services.

   Each patient's health record shall meet these requirements:
   a. Be legible in both readability and content.
   b. Contain only those terms and abbreviations that are or should be comprehensible to similar providers/peers.
   c. Contain patient-identifying information on each page to ensure pages are not lost or misfiled.
   d. Indicate the dates any professional service was provided and date of each entry.

e. Contain pertinent information concerning the patient's condition and justify the course of treatment. The record must document the medical necessity and appropriateness of each service.
f. Documentation of examination and treatment(s) performed or recommended (why it was done and for how long) and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed, and the results of each.
g. List start and stop times or total time for each CPT code/service performed on all timed codes per CPT nomenclature.
h. Document the initial diagnosis and the patient's initial reason for seeking the provider's care.
i. Document the patient's current status and progress during the course of treatment provided.
j. Indicate the medications prescribed, dispensed, or administered, and the quantity and strength of each.
k. Include all patient records received from other health care providers if those records formed the basis for treatment decision by the provider.
l. Each entry shall be authenticated by the person making the entry (see Signature Requirements) unless the entire patient record is maintained in the provider's own handwriting.
m. Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.

4. Signature Requirements – In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.
   a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date.
   b. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.

c. An electronic signature is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author's first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: "Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M."

d. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.

e. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

5. Corrections in the Medical Record – If the original entry in the medical record is incomplete, contracting providers shall follow the guidelines below for making a correction, addendum, or amendment. Signature requirements as defined above apply to all corrections in the medical record.

   a. Errors in paper-based records -- To add an addendum or amendment to paper-based records, draw a single line in ink through the incorrect entry, print the word "error" at the top of the entry, the reason for the change, the correct information, and authenticate the error by signing (including credentials) the notation with the date and time. Entries should not be antedated (assigned a date earlier than the current date). Errors must never be blocked out or erased.

   b. Electronic medical records/Electronic health records:

      i. Addendum – An addendum is new documentation used to add information to an original entry that has already been signed. Addenda should be timely with date and time of the addendum. Write "addendum" and state the reason for the addendum referring back to the original entry.

      Complete the addendum as soon after the original note as possible. Identify any sources of information used to support the addendum. Entries should not be antedated (assigned a date earlier than the current date).

ii. Amendment – An amendment is documentation meant to clarify or provide additional information within the medical record in conjunction with a previous entry. An amendment is made after the original documentation has been completed and signed by the provider. All amendments should be timely with the date and time of the amended documentation. Write "amendment" and document the clarifying information referring back to the original entry. Complete the amendment as soon after the original note as possible. Entries should not be antedated (assigned a date earlier than the current date).

6. Use of Medical Scribes – Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider. BCBSKS expects the signing and dating of all entries made by a scribe to be identifiable and distinguishable from that of a physician or licensed independent practitioner. All entries made by a scribe are ultimately the practitioner's responsibility; therefore, review of the documentation and verification of its accuracy, including authentication by the practitioner, is required.

V. Additional Information/Education

CMS 1500 Claim Form Tutorial

Professional Provider Manual

Insurance Workshops

Limited Patient Waiver

Additional information and education can be found at bcbsks.com, under the Professional Provider tab.

Revisions

06/01/2018	Redesigned manual.
	Page 5 – Updated Refraction 92015 with Medical Eye Examination information.
	Page 8 – Updated Disposable Contacts information.
01/01/2019	Page 4 – Added code H52.6 to Diagnosis Codes Considered Routine.
	Page 11 – Added verbiage for reimbursement for standard lens.
	Page 12 – Added verbiage to Pediatric Vision Coverage under BlueCare Plans.
01/01/2020	Page 5 – Updated Accident/Medical Emergency Diagnosis on Claim verbiage to reflect current practices.
	Page 11 – Updated Cataract Surgery verbiage to reflect current practices.
	Page 12 – Moved paragraph to intro to relate to entire section.
01/31/2020	Page 9 – Removed Keratoconus verbiage.
	Page 10 – Updated Optical Coherence Tomography (OCT) of the Anterior Eye Segment verbiage to reflect current practices.
01/01/2021	Page 5 – Removed Refraction 92015 verbiage.
	Page 6 – Updated Accident/Medical Emergency Diagnosis on Claim Form verbiage to reflect current practices.
	Page 6 – Added new section, Refraction 92015.
	Page 6 – Added verbiage to Content of Service.
	Page 8 – Updated Coverage verbiage to reflect current practices.
	Page 10 – Updated wording about Visual Field testing to reflect current practices.
	Page 11 – Updated wording under Cataract Surgery to reflect current practices.
	Page 13 – Added verbiage to Eyeglasses (standard frames)
	Page 16 – Added section, Documentation Requirements/Medical Records.
	Page 19 – Added section, Additional Information/Education
	Page 20 – Added Limited Patient Waiver
05/24/2021	Page 10 – Updated wording about Visual Fields to reflect current practices.
01/01/2022	Page 5 – Clarified wording about refractions.
	Page 10 – Added Avastin Coding section.
	Page 11 – Added information regarding Visual Fields and Visual Field codes billed alone.
03/16/2022	Page 10 – Updated Avastin Coding Section for consistency across payers
01/01/2023	Page 4 – Added Coverage Clarification Section

	Page 15 – Updated Hardware Coverage After Cataract Surgery section, added last two bullets
	Page 16 – Updated title of Pediatric Vision Coverage under ACA Products
	Page 16 – Added deluxe information under section II. Eyeglasses (Standard Frames)
	Page 18 – Added deluxe information under Waiver of Liability section
02/2023	Page 6 – Updated all references of “preventive” to “routine” throughout for consistency in the “Routine Eye Examinations (Standard Benefit)” section, previous “Preventive Eye Examinations (Standard Benefit)” section
	Page 7 – Updated any reference to preventive to routine for consistency
	Page 12 – Updated Visual Fields section to reflect current billing practices
01/01/2023	Page 4 – Added chapter I. Important contact information
	Page 6 – Updated section I to reflect current benefit information for eye exams
	Page 7 – Updated section III to add clarification in billing refractions
	Page 8 – Updated section IV to remove last two bullets
	Page 10 – updated section I to reflect current practices
	Page 11 – updated dispensing section II to clarify coverage of lenses
	Page 11 – Added section IV on deluxe services, changing section numbers after by one in this chapter
	Page 13 – Updated section VI to reflect current visual field practices
	Page 13 – removed medical policy info beneath section IX
	Page 13 – updated section X to current practices
	Page 15 – removed deluxe services and moved to page 11
	Page 16 – added last bullet under section II

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