Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Vision

Updated 05.2025

PART II
VISION FEE-FOR-SERVICE PROVIDER MANUAL

Introduction

FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare Managed Care Organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

PART II
VISION FEE-FOR-SERVICE PROVIDER MANUAL

Updated 01/18

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to vision providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection gives information on billing for applicable vision services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of vision services allowed within the Kansas Medical Assistance Program (KMAP).

The **Appendix** subsection contains information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

7000. VISION BILLING INSTRUCTIONS Updated 08/23

Introduction to the CMS 1500 Claim Form

Providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider. The Kansas Modular Medicaid System (KMMS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

An example of the paper CMS 1500 Claim Form and instructions are on the KMAP public and secure websites under the Publications tab on the Forms page under the Claims (**Sample Forms and Instructions**) heading.

Any of the following billing errors may cause a paper CMS 1500 claim to deny or be sent back to the provider:

- Sending a KanCare paper claim to KMAP.
- Sending a CMS 1500 Claim Form carbon copy.
- Using a PO Box in the Service Facility Location Information field.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

SUBMISSION OF CLAIM

Send completed claim and any necessary attachments to:

Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

7020. VISION SPECIFIC BILLING INFORMATION Updated 05/25

Complete the CMS 1500 Claim Form if the vision services meet the following criteria:

- The services provided are all professional (no material charges).
- The services are both professional and materials and the provider receives the payment for materials.

An invoice is **not** required.

Diagnosis Codes

Applicable ICD-10 diagnosis codes are required on all claims submitted for processing. Opticians and optometrists should share these codes with the dispenser.

Cataract Surgery

If vision services such as eye exams, lenses, or frames are being rendered due to cataract surgery (diagnosis codes H2640, H26419, H26499, or H2703) or lens replacement (diagnosis code Z961), the date of surgery must be present in Field 19 of the CMS 1500 Claim Form. If the date of surgery is not present, the services will be denied.

Vision Allowable Places of Service

Effective with dates of service on or after November 1, 2023, the places of service listed below are acceptable for all vision codes listed in the Appendix, pages A-1 and A-2 of this manual, unless otherwise noted:

- 05 – Indian Health Service Free-standing Facility
- 07 – Tribal 638 Free-standing Facility
- 11 – Office
- 15 – Mobile Unit (only covered for codes in range 92002 – 92499)
- 17 – Walk-in health clinic
- 19 – Off Campus-Outpatient Hospital (Only covered for 92021, 92082, and 92083)
- 21 – Inpatient Hospital – billed by the hospital under a revenue code (only exam codes)
- 22 – On Campus-Outpatient Hospital (Only covered for 92081, 92082, and 92083)
- 23 – Emergency Room Hospital (Only covered for 92081, 92082, and 92083)
- 49 – Independent Clinic
- 50 – Federally Qualified Health Center (Only 92002, 92004, 92012, and 92014 are covered)
- 71 – Public Health Clinic (Only 92002, 92012, and 92081 are covered)
- 72 – Rural Health Clinic (Only 92002, 92004, 92012, and 92014 are covered)

"New Patient" Visit Coding:

The vision services rendered by a physician or qualified health care professional within the same group practice do not qualify as "new patient" visits if provided within three years of a previous encounter. The covered subsequent visits must be billed as "established patient" visits if provided within three years of a previous encounter for providers affiliated with the same group (identified by the same National Provider Identifier [NPI]), regardless of specialty. These guidelines apply to all providers within the same provider group, including physicians (across all subspecialties), optometrists, Advanced Practice Registered Nurses (APRNs), and Physician Assistants (PAs).

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 12/23

Copayments will no longer apply to Kansas Medicaid Fee-for-Service (FFS) members. The mandatory managed care authority for KanCare is transitioning from the 1115 Waiver to the Medicaid State Plan and a 1915b Waiver. Copayments are being removed from the Medicaid State Plan and will not apply to FFS members.

Managed Care members will continue to be exempt from copayments.

BENEFITS AND LIMITATIONS

8300. Benefit Plan Updated 01/18

KMAP members will be assigned to one or more benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 03/24

Eye Exams
One complete eye exam is covered every year (365 days) when provided by ophthalmologists and optometrists for non-KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) members. Eye exams are covered as needed up to one year following cataract surgery when provided by ophthalmologists and optometrists. Eye exams are limited to one every year (365 days); however, a total of two eye exams are covered per month to detect and/or follow medical conditions.

Eye exams are covered as needed for KBH-EPSDT members when provided by ophthalmologists and optometrists. The following basic eye exam procedure codes are considered KBH-EPSDT vision screens: 92002, 92004, 92012, 92014, and 99173*.

*Modifier 25 can be billed with a KBH Evaluation and Management (E/M) code when code 99173 is billed for the same KBH visit.

Since ophthalmologists and optometrists provide more extensive eye examinations than are reflected by a KBH-EPSDT vision screening code, these vision providers must bill vision exams using one of the codes listed in the appendix of this manual.

Refraction (92015) is not included in a basic eye exam. Refractions may be provided on the same date of service as the basic eye exam and billed as a separate procedure.

If visual field examinations, fundus photography, and laser scanning are performed on the same date of service as an eye exam, visual field examinations, fundus photography, and laser scanning are considered content of service of that eye exam unless medical necessity is shown.

Visual field examinations and laser scanning are not allowed on the same date of service. Both procedures are limited to a total of four times per 365 days if medical necessity is present. (Laser scanning is limited to four per year. Modifier LT or RT is no longer required when billing laser scanning.)

Visual field testing must be medically necessary to establish a diagnosis, monitor a course of treatment, or determine if a change in therapeutic plan is necessary because of a progression of a disease. Furthermore, the lowest level of testing medically necessary should be used. Glaucoma is the most frequent diagnosis associated with visual field testing. Visual field testing may be medically necessary in a glaucoma suspect or a patient with glaucoma, mild damage, and good control only once every year. Visual field testing may be necessary in patients with moderate glaucoma and good control once a year. Field testing may be necessary in mild, moderate, or advanced glaucoma and borderline control two times a year. Finally, visual field testing in patients with advanced damage or uncontrolled glaucoma may be necessary up to four times a year.

Fundus photography and visual field examinations are considered content of service of an eye exam when performed on the same date of service unless the diagnosis on the claim clearly supports medical necessity for the procedure.

8400. MEDICAID Updated 04/19

Eye Exams continued
Laser scanning is appropriate once a year to follow pre-glaucoma patients or those with mild damage. Patients with moderate damage may be followed with either scanning or visual field testing. Using scanning **and** visual field testing is not allowed. Patients with moderate damage may be followed with two tests per year. If the glaucoma is uncontrolled, more than two tests per year (up to the limit of four tests) may be necessary. Finally, in advanced damage, visual field testing is preferred instead of laser scanning.

Corneal topography is allowed no more than one time per year with prior authorization. Medical necessity must be shown by one of the following diagnosis codes.

- Use ICD-10 code H18459, H18469, H18609, H18619, H18629, T85398A, or Z947. Corneal topography is noncovered for preparation or continued care of LASIK surgery or basic fitting or refitting of contact lenses.

LASIK surgery is noncovered.

Documentation
Documentation in the member's medical record must support the service billed in the course of a post payment review. Refer to **Section 2700** of the *General Benefits Fee-for-Service Provider Manual* for KMAP documentation requirements.

Eyeglasses
All frames must include a one-year warranty.

Backup eyeglasses are noncovered and should not be billed to KMAP.

Eyeglasses may initially be ordered on the same date a KBH-EPSDT vision exam is performed.

The fitting of new eyeglasses is considered content of service of the charge for the glasses and cannot be billed separately.

Eyeglasses are covered up to no more than three sets of lenses and three pairs of frames per 365 days (one year) for KBH-EPSDT members. Replacement parts may be covered.

Eyeglasses are covered up to no more than one set of lenses and one pair of frames per year for non-KBH-EPSDT members.

If only one lens or just frames are issued to the non-KBH-EPSDT participant after the one year limitation, the patient remains eligible to receive the other lens and/or frames. The provider needs to verify with Customer Service at 1-800-933-6593 to determine if the member qualifies for further coverage before billing the KMAP member. Minor repairs to eyeglasses may be covered.

8400. MEDICAID Updated 12/10

Eyeglasses continued
The date of receipt of the prescription (ordering date) is considered the date of service. The provider may bill KMAP before the actual dispensing of the glasses since the intent to render service has been confirmed by the acceptance of the prescription.

Optometrists and ophthalmologists who provide eyeglass dispensing services to non-KMAP members must offer this service to KMAP members. This policy is monitored on a post payment basis.

If a member chooses eyeglass frames or lenses that exceed KMAP's allowed amount, the member is responsible for the entire expense of the frames or lenses. Do not bill KMAP for these services.

Eyeglasses for post cataract surgery patients are covered when provided within one year following the cataract surgery.

All sunglasses, transition lenses, tints (including photochromatic), progressive lenses, safety glasses, and athletic glasses are noncovered.

Polycarbonate lenses are covered with medical necessity. Polycarbonate lenses are billed using one of the following options:

- V2784 (This code is NOT in addition to and cannot be billed with any other lens codes.)
- S0580 (List this code in addition to the basic code for the lens. If using S0580, providers should bill this code in addition to the appropriate lens code.)

Codes V2784 and S0580 cannot be billed together. Polycarbonate lenses are noncovered for convenience or cosmetic reasons. Modifier 22 is no longer required. If a member chooses polycarbonate lenses when medical necessity does not exist, the member is responsible for the entire cost of the lens.

Contact Lenses
Prior authorization is required for all contact lens services. Backdating a prior authorization is not allowed. Providers must obtain a prior authorization approval from KMAP before dispensing contacts. The following member information must be provided with a prior authorization request:

- Eyeglass lens prescription and the visual acuity achieved with this correction in both eyes
- Visual acuity without correction
- Type of contact lenses to be fitted
- Date of original fitting
- Reason for refitting, if applicable
- Medical necessity for contact lenses
- Outline of adaptation procedures
- Probability of need for supplemental eyeglass lenses
- Approximate cost to KMAP

8400. Medicaid Updated 12/15

Contact Lenses continued
Contact lenses and replacements are covered with prior authorization for the following (medical necessity must be present):

- Monocular aphakia
- Bullous keratopathy
- Keratoconus
- Corneal transplant
- Anisometropia of more than three diopters of difference that is causing vision distortion and cannot be corrected with glasses
- Aniseikonia of more than three diopters of difference that is causing vision distortion and cannot be corrected with glasses

Contact lens adaptation includes six months of care.

Contact lens replacement includes neutralization per lens.

Contact lenses are noncovered for cosmetic purposes or for athletic participation. Contacts which are colored or tinted of any kind are noncovered.

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

Blepharoplasty and Blepharoptosis
Blepharoplasty and blepharoptosis procedures require prior authorization. The member must meet the following criteria:

- Margin Reflex Distance (MRD) must be 1.0 or less in the best eye.
- Full Flash Photo light reflex must be performed to identify papillary center resting tangent.
- Visual field loss must be 10-15 degrees above dead center in the best eye for members 14 years of age and older. Submit with request visual field loss of both eyes (taped and untaped).
- Prior vision history and expected outcomes of surgery must be submitted with request.
- If best eye does not meet the above criteria, the surgery is not allowed except in members less than 10 years of age.
- For coverage of one eye, the same criteria applies unless person only has one functional eye.
- For coverage of both eyes, the best eye must meet all the above criteria.
- All the above information must be submitted at the time the prior authorization request is made. Requests cannot be processed without all the above information.

Vision Therapy
Orthoptic and/or pleoptic training (also referred to as vision therapy) is a noncovered KMAP benefit. No services are payable arising from the assessment, planning, implementation, or evaluation of vision therapy.

8400. Medicaid Updated 12/15

Emergency Medical Services for Aliens (SOBRA)
In addition to inpatient hospital and emergency room hospital, emergency services performed in outpatient facilities and related physician, lab, and x-ray services will be allowed for the following places of service: office, outpatient hospital, federally qualified health clinic, state or local public health clinic, rural health clinic, ambulance, and lab for SOBRA claims. Inpatient hospital reimbursement will not be limited to 48 hours. Follow-up care will not be allowed once the emergent condition has been stabilized.

Refer to **Section 2040** of the *General Benefits Fee-for-Service Provider Manual* for specific information.

APPENDIX
CODES

Updated 05/25

The following codes represent a list of vision services billable to KMAP. Refer to **Section 8400** of this manual for additional benefits and limitations.

Please use the following resources to determine current coverage and pricing information. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan.

- Information is available on the public website.
- Information is available on the secure website under Pricing and Limitations.

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the public and secure websites. They can be accessed from the Reference Codes tab of the Interactive Tools heading on the Provider page. Information is available on the American Medical Association website.

COVERAGE INDICATORS

KBH-EPSDT	-	KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment participation is required.
PA	-	Prior authorization is required.
C	-	Covered KMAP service.
MN	-	Medically Necessary.

PROFESSIONAL SERVICES - EYE EXAMINATIONS

92002*	C	92004*	C	92012	C	92014	C	92015	C
92020	C	92025	C, PA	92081	C	92082	C	92083	C
92100	C	92132	C	92133	C	92134	C	92250	C
92285	C								

*The new patient visit codes 92002 and 92004 are limited to one visit per three years for providers affiliated with the same group (identified by the same National Provider Identifier [NPI]), regardless of specialty.

APPENDIX
CODES

Updated 09/23

LENSES, FRAMES, AND MATERIALS

92370	C	S0580	C	V2020	C	V2100	C	V2101	C
V2102	C	V2103	C	V2104	C	V2105	C	V2106	C
V2107	C	V2108	C	V2109	C	V2110	C	V2111	C
V2112	C	V2113	C	V2114	C	V2115	C, PA	V2118	C, PA
V2121	C, PA	V2199	C, MN	V2200	C	V2201	C	V2202	C
V2203	C	V2204	C	V2205	C	V2206	C	V2207	C
V2208	C	V2209	C	V2210	C	V2211	C	V2212	C
V2213	C	V2214	C	V2215	C, PA	V2218	C, PA	V2219	C
V2220	C	V2221	C, PA	V2299	C	V2300	C	V2301	C
V2302	C	V2303	C	V2304	C	V2305	C	V2306	C
V2307	C	V2308	C	V2309	C	V2310	C	V2311	C
V2312	C	V2313	C	V2314	C	V2315	C, PA	V2318	C, PA
V2319	C	V2320	C	V2321	C, PA	V2399	C	V2410	C, PA
V2430	C, PA	V2499	C, PA	V2710	C	V2715	C	V2760	C
V2782	C	V2783	C	V2784	C	V2799	C, MN		

CONTACT LENS – ADAPTATION

92071	C, PA	92072	C, PA	92310	C, PA	92311	C, PA	92312	C, PA
92313	C, PA	92314	C, PA	92315	C, PA	92316	C, PA	92317	C, PA
92325	C, PA	92326	C, PA	S0500	C, PA	V2500	C, PA	V2501	C, PA
V2502	C, PA	V2503	C, PA	V2510	C, PA	V2511	C, PA	V2512	C, PA
V2513	C, PA	V2520	C, PA	V2521	C, PA	V2522	C, PA	V2523	C, PA
V2530	C, PA	V2531	C, PA						

ARTIFICIAL EYES
(Includes both Professional and Material Charges)

V2623	C	V2624	C	V2625	C	V2626	C	V2627	C
V2628	C								