

CHAPTER 62

VISION CARE SERVICES MANUAL

Authority

N.J.S.A. 30:4D-6a(5), b(6), (7); 7a, b, and c;
30:4D-12; 42 CFR 440.50, 440.120.

Source and Effective Date

R.1994 d.6, effective December 7, 1993.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Executive Order No. 66(1978) Expiration Date

Chapter 62, Vision Care Services Manual, expires on December 7, 1998.

Chapter Historical Note

Chapter 62, Vision Care Services Manual, became effective October 18, 1971 as R.1971 d.142. See: 3 N.J.R. 25(c), 3 N.J.R. 178(e).

1973 Revisions: Amendments became effective September 1, 1973 as R.1973 d.197. See: 5 N.J.R. 44(a), 5 N.J.R. 281(b).

1974 Revisions: Amendments became effective August 30, 1974 as R.1974 d.181. See: 6 N.J.R. 65(b), 6 N.J.R. 312(c).

1975 Revisions: Amendments became effective September 1, 1975 as R.1975 d.261. See: 7 N.J.R. 316(c), 7 N.J.R. 465(b).

1979 Revisions: Amendments became effective February 14, 1979 as R.1979 d.60. See: 10 N.J.R. 539(b), 11 N.J.R. 132(c).

1981 Revisions: Amendments became effective July 9, 1981 as R.1981 d.249. See: 13 N.J.R. 293(a), 13 N.J.R. 417(a). Further amendments became effective September 10, 1981 as R.1981 d.331. See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).

1983 Revisions: Subchapters 1, 2 and 4 were readopted pursuant to Executive Order 66(1978) effective December 19, 1983 as R.1983 d.620. See: 15 N.J.R. 1731(a), 16 N.J.R. 144(b).

1986 Revisions: Subchapter 4 was repealed and a new subchapter became effective March 3, 1986 as R.1986 d.52. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a). Subchapter 3 was readopted pursuant to Executive Order 66(1978) effective March 6, 1986 as R.1986 d.90. See: 17 N.J.R. 2731(b), 18 N.J.R. 689(a). Amendments became effective June 16, 1986 (operative July 1, 1986) as R.1986 d.236. See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

1987 Revisions: Subchapter 3 was substantially amended and recodified effective October 5, 1987 as R.1987 d.408. See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

1988 Revisions: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriation Act (P.L. 1988 c.47), maximum fee allowance increases for routine visit in 4.3 for August 1, 1988 and May 1, 1989 and also for vision care appliances effective August 1, 1988 and May 1, 1989. See: 20 N.J.R. 2101(a). Subchapters 1, 2 and 3 were repealed and new subchapters 1, 2 and 3 of the "Vision Care Services Manual" became effective December 19, 1988 as R.1988 d.580. See: 20 N.J.R. 956(c), 20 N.J.R. 3147(a).

Pursuant to Executive Order No. 66(1978), Chapter 62 was readopted as R.1994 d.6. See: Source and Effective Date. As a part of R.1994 d.6, existing Subchapter 3, Billing Procedures, and Subchapter 4, referencing HCPCS, were repealed and a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted, effective January 3, 1994. See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a). See, also, section annotations for specific rulemaking activity.

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SUBCHAPTER 1. EYE CARE: PROFESSIONAL SERVICES

10:62-1.1 Scope

This subchapter delineates the New Jersey Medicaid program's standards for examinations and care for vision defects and/or eye diseases for the purpose of maintaining or improving the health of New Jersey Medicaid recipients.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Ophthalmologist" means a fully licensed medical doctor who has been recognized by the New Jersey Medicaid program as a specialist in ophthalmology.

"Optometrist" means any person who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or licensed to engage in the practice of optometry in the state in which he or she performs such functions.

"Practitioner" means a licensed ophthalmologist or optometrist, acting within the scope of licensure.

"Transfer" means the relinquishing of responsibility for the continuing care of the recipient by one practitioner and the assumption of such responsibility by another practitioner.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.3 Providers of professional services

(a) Within the restrictions of their respective licensure, the following are eligible providers of eye care upon fulfilling the enrollment process requirements in N.J.A.C. 10:49-3.2:

1. Ophthalmologists or optometrists licensed in the State of New Jersey;
2. Ophthalmologists or optometrists in another state who are duly licensed in that state;
3. Independent clinics approved by the New Jersey Medicaid program to render eye care services; and
4. Hospitals meeting the definition of "approved hospital" as described in N.J.A.C. 10:52-1.1 of the Hospital Services Manual.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.4 Covered services

Professional services include office visits for evaluation and management, comprehensive eye examinations, low vision examinations, low vision work-ups, vision training work-ups, vision training program visits as well as other specific procedures as listed at N.J.A.C. 10:62-3.2. Payment is made subject to the limitations specified under each type of service. If a service requires prior authorization, see N.J.A.C. 10:62-1.10.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.5 Comprehensive eye examination

(a) A comprehensive eye examination may include cycloplegics and a post cycloplegic visit. All findings and data, including positive and negative, shall be clearly recorded. A comprehensive eye examination shall include the following, as a minimum, where possible unless contraindicated:

1. Detailed case history;
2. Complete visual acuity findings;
3. External and internal (ophthalmoscopic) examination including slit lamp;
4. Refraction (objective and subjective);
5. Extra-ocular measurement (EOM);
6. Gross visual fields (central and peripheral);
7. Tonometry (when indicated for patients under 35; mandatory for all patients over 35). The specific method used should be identified and recorded (the finger palpation test is not acceptable);
8. Binocular coordination testing (distance and near), fusion, stereopsis, and color vision;
9. The diagnosis (ocular deficiency or deformity, visual or muscular anomaly, and so forth); and
10. Recommendations.

10:62-1.6 Low vision examination

A low vision examination as defined in N.J.A.C. 10:62-3.3 may be performed following a comprehensive eye examination when the vision in the better eye is 20/70 or less with the best correction.

Recodified from 10:62-1.7 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Prior text at 10:62-1.6, Routine office visit or follow-up visit, repealed.

10:62-1.7 Low vision work-up

A low vision work-up as defined in N.J.A.C. 10:62-3.3 requires prior authorization (see N.J.A.C. 10:62-1.9). For purposes of the New Jersey Medicaid program, a low vision work-up consists of certain testing techniques and procedures to determine what optical aids and devices can be prescribed for an individual to increase range of vision. A low vision work-up requires a written report and is much more detailed than the low vision examination that follows a complete comprehensive examination.

Recodified from 10:62-1.8 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.8 Vision training program

(a) Vision training requires prior authorization (see N.J.A.C. 10:62-1.9). For purposes of the New Jersey Medicaid program, vision training is the use of certain procedures and modalities for the development of and/or increase in the vision capacity of the eye(s) with poor and/or inconsistent or distorted vision localization.

(b) Vision training is limited to orthoptics, with its acceptable procedures and/or modalities, and further limited to the following types of conditions to be treated by private physicians approved for such training by the respective peer group:

1. Strabismus;
2. Amblyopia;
3. Heterophoria; and
4. Accommodative and/or convergence anomalies.

(c) If vision training is required following the initial comprehensive eye examination, the practitioner shall submit a written request (form FD-358) to Vision Care Unit for prior authorization (see N.J.A.C. 10:62-1.9) for a vision training work-up. This request shall include the preliminary findings, detailed reason(s) why it is believed a further evaluation is needed, and any history of previous vision training with the dates and the results. Upon receiving approval for a vision training work-up, the practitioner shall then submit, within 30 days of receipt of authorization, the work-up report to the Vision Care Unit. The vision training work-up report shall consist of, but not be limited to:

1. Diagnosis;
2. Findings;
3. Interpretation;
4. Recommendations;
5. Outline of training procedures and frequency of sessions with estimated duration of treatment; and
6. Prognosis.

(d) The decision of the Vision Care Unit to approve or deny vision training will be transmitted to the practitioner by the fiscal agent.

(e) Upon completion of an approved training program, the practitioner shall submit a detailed progress report, listing the status of all parameters indicated in the original evaluation. No treatment plan shall exceed a period of 90 days or a total of 30 training visits, commencing with the inception of the treatment plan. An additional prior authorization is required for any extension of treatment and requires submission of a detailed progress report to the Vision Care Unit.

(f) Vision training may be provided by a practitioner when found medically necessary. This service can be performed in the office or in an independent clinic approved by the New Jersey Medicaid program.

Recodified from 10:62-1.9 and amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.9 Professional services requiring prior authorization

(a) Form FD-358 (Request for Prior Authorization for Vision Care Services) shall be used to request prior authorization for professional services. Instructions for completing the form are provided in the Fiscal Agent Billing Supplement. The completed form, clearly indicating the reasons for requesting the service requiring prior authorization, shall be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, Mail Code # 16, CN 712, Trenton, New Jersey 08625-0712. When a request for prior authorization is approved or denied, the provider shall receive a letter of notification from the fiscal agent.

(b) Items requiring prior authorization should not be provided to the Medicaid recipient until the authorization is received by the provider from the fiscal agent.

(c) The following professional services require prior authorization:

1. Low vision work-up;
2. Vision training program;
3. Vision training work-up; and
4. All other services not specified as a covered service under N.J.A.C. 10:62-1.4.

(d) Vision care provider services rendered to Medicaid recipients who are enrolled in a health maintenance organization which includes these services in its benefits package must be prior authorized by the HMO/physician case manager. (See N.J.A.C. 10:49-19 and 10:49-20 for specifics on prepaid health plans, the Garden State Health Plan, which serves the Medicaid population, and the Fiscal Agent Billing Supplement, for details for obtaining prior authorization.

Recodified from 10:62-1.10 and amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.10 Prescription policies

(a) Upon request, a recipient must be provided with his or her prescription for an optical appliance. The following information shall be indicated on the prescription: Name, address, HSP (Medicaid) Case Number, date of examination, and diagnosis code(s).

(b) If a recipient requests a duplicate prescription, the duplicate prescription shall clearly indicate: "THIS IS A

DUPLICATE". The date of the original prescription shall also be included. The dispensing provider shall retain the original prescription.

Recodified from 10:62-1.11 and amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.11 Recordkeeping policies

(a) Providers shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. Data shall include such quantitative positive and negative findings as will be meaningful in a subsequent review. Check marks are not acceptable. The information shall be readily available to representatives of the New Jersey Medicaid program, or its agents, as required.

(b) Records shall be kept and maintained by the provider for a period of at least five years from the date the service was rendered.

Recodified from 10:62-1.12 and amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.12 Reimbursement policies

(a) Instructions for submitting claims for payment of vision care services are provided in the Fiscal Agent Billing Supplement.

(b) Vision care services shall be identified by means of procedure codes, utilizing the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

(c) The provider shall use his or her usual and customary charge when submitting a claim for vision care services. Reimbursement for covered services furnished under the New Jersey Medicaid program shall be made on the basis of the provider's customary charge, not to exceed an allowance determined to be reasonable by the Commissioner of the Department of Human Services, and further limited by federal policy (policy 42 CFR 447 Subpart B) relative to payment of practitioners and other individual providers.

1. In no event shall the charge to the New Jersey Medicaid program exceed the charge by the provider for identical services to other governmental agencies, private nonprofit agencies, trade unions or other individuals in the community.

2. If a recipient receives care from more than one member of a partnership or corporation in the same discipline for the same service, the maximum payment allowance shall be the same as that of a single provider. For purposes of reimbursement, optometrist and/or physician, optometrist and physician groups, shared health care facility, or optometrist and physician sharing a common record shall be considered a single provider.

3. Reimbursement shall not be made for, and recipients may not be asked to pay for, broken appointments.

(d) For reimbursement purposes, when the practitioner submits a claim for services, the services shall have been performed personally by the practitioner submitting the claim.

(e) To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the recipient's medical record must contain the practitioner's notes indicating that he or she personally:

1. Reviewed the recipient's medical history with the recipient and/or his or her family, depending upon the medical situation;
2. Performed an eye examination, or other procedure;
3. Established, confirmed or revised the diagnosis; and
4. Visited and examined the recipient on the day(s) for which a claim for reimbursement is made.

Recodified from 10:62-1.13 and amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

SUBCHAPTER 2. OPTICAL APPLIANCES AND SERVICES

10:62-2.1 Scope

This subchapter covers the provision of optical appliances necessary for the correction of any eye vision defects.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Ocularist" means a provider of artificial eyes.

"Optical appliances" mean those items, devices or appliances prescribed by a practitioner in order to aid or improve vision, or to replace the eye.

"Optician" means an individual licensed by the New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, or licensed to practice as an optician in the state in which he or she performs such functions.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.3 Providers of optical appliances and other services

(a) Within the restrictions of their respective licensure, the following are eligible providers upon fulfilling the Enrollment Process requirements in N.J.A.C. 10:49-3.2;

1. Ophthalmologists as defined in N.J.A.C. 10:62-1.2;
2. Optometrists as defined in N.J.A.C. 10:62-1.2;
3. Opticians as defined in N.J.A.C. 10:62-2.2;
4. Ocularists as defined in N.J.A.C. 10:62-2.2;
5. Independent clinics approved by the New Jersey Medicaid program to render eye care services;
6. Hospitals approved by the New Jersey Medicaid program for participation; and
7. Ophthalmologists, optometrists or opticians in another state who are duly licensed or meet the requirements of their own state with regard to the dispensing of optical appliances within that state.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.4 Covered services

(a) The following optical appliances and services are covered under the New Jersey Medicaid program:

1. Optical lenses (see N.J.A.C. 10:62-2.6);
2. Optical frames (see N.J.A.C. 10:62-2.7);
3. Repairs of optical appliances (prior authorization required for repairs for which the charge to the Medicaid program is \$15.00 or over (see N.J.A.C. 10:62-2.5);
4. Artificial eyes (may be provided once every three years when prescribed by an ophthalmologist or an optometrist);
5. Low vision devices (prior authorization required if the total charge to the Medicaid program is \$150.00 or more, see N.J.A.C. 10:62-2.5);
6. Vision training devices (prior authorization required, see N.J.A.C. 10:62-2.5);
7. Replacement of optical appliances:
 - i. Lenses and frames may be replaced once every two years for persons age 19 through and including 59 years of age, and once a year for persons less than 19 years or 60 years of age and older, provided there is a change of 0.50 diopter in sphere and or cylinder power, or a change of five degrees or more in cylinder axis.
 - ii. Lenses may be replaced more frequently than once every two years for persons 19 through and including 59 years of age or more frequently than once every year for persons less than 19 years or 60 years of age and older, providing there is a prescription change of at least 0.75 diopter in spherical and/or cylindrical power

or a change in axis of eight degrees or more. Providers shall enter the previous prescription number in the Remarks section (# 19) of the MC-9 claim form.

iii. When an optical appliance is destroyed in a fire or stolen, the provider shall place a written statement in the Remarks section (# 19) of the MC-9 claim form and put a copy of the fire/police report in the provider's recipient file.

iv. Providers may provide one replacement of frame and/or lenses per year for individuals with developmental disabilities. Providers shall place a written supporting statement and diagnosis related information in the Remarks section (# 19) of the MC-9 claim form and put a copy of the developmental disabilities report in the provider's recipient file.

8. Dual pairs of glasses instead of multifocal (prior authorization required, see N.J.A.C. 10:62-2.5);
9. Contact lenses; and
10. Intraocular lenses.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.5 Optical appliances requiring prior authorization

(a) Form MC-9(A) (Request for Authorization and Payment—Optical Appliances) shall be used for requesting prior authorization for optical appliances. Instructions for completing the form are provided in the Fiscal Agent Billing Supplement. The completed form clearly indicating the reasons for requesting the appliance requiring prior authorization, must be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, Mail Code # 16, CN712, Trenton, New Jersey 08625-0712. When a request for authorization is approved or denied, the provider shall receive a letter of notification from the fiscal agent.

(b) Items requiring prior authorization should not be provided to the Medicaid recipient until the authorization is received by the provider. (Reference is made to N.J.A.C. 10:49-6).

(c) Authorization becomes invalid upon termination of eligibility for the New Jersey Medicaid program, except when the termination occurs between the time the optical appliance is ordered and the time the optical appliance is dispensed. Note: The provider shall use the date the optical appliance is ordered as the date of service when this situation occurs.)

(d) The following optical appliances require prior authorization:

1. Low vision devices when the total charge to the Medicaid program is \$150.00 or more;
2. Vision training devices;

3. Repair of an optical appliance when the charge to the Medicaid program is \$15.00 or more;
4. Replacement of optical appliances;
 - i. In circumstances not covered in N.J.A.C. 10:62-2.4, the replacement of an optical appliance requires prior authorization. For example: If lost, broken and irreparable, or prescription change is less than 0.50 diopter or 5 degrees in axis.
5. Dual pairs of glasses instead of multifocal;
6. Optical tints (except rose, one and two, grey or brown plastic lenses 10 percent to 20 percent);
7. High index lenses;
8. Special base curve; and
9. All other optical appliance items requiring additional charges or not identified in N.J.A.C. 10:62-3.4 (Procedure Codes and Maximum Fee Schedule for Vision Care Appliances).

(e) Optical appliance services rendered to Medicaid recipients who are enrolled in a health maintenance organization which includes these services in its benefits package must be prior authorized by the HMO/physician case manager. See N.J.A.C. 10:49-19 and 10:49-20 for specifics on prepaid health plans and the Garden State Health Plan which serve the Medicaid population and the Fiscal Agent Billing Supplement for details for obtaining prior authorization.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.6 Standards and policies regarding lenses

(a) Lenses shall be first quality ophthalmic lenses meeting the requirements published by American National Standard Institute (available from the American National Standards Institute, 11 West 42 St., New York, N.Y. 10036, tel. 212-642-4900.

(b) Safety lenses shall meet impact resistant standards as set forth in the United States Food and Drug Administration regulations (21 CFR 3.84).

(c) For pricing purposes, all prescriptions shall be written in minus cylinder form.

(d) The total correction shall be at least 0.50 diopter in spherical or cylindrical power in the initial prescription for glasses.

(e) New lenses are reimbursable only if a change exists; that is, at least 0.50 diopter in spherical or cylinder power, or a change of five degrees or more in cylindrical axis.

(f) Contact lenses may be provided for:

1. Specific ocular pathological conditions (for example, Keratoconus, monocular surgical aphakia to effect binocular vision, anisometropia of 3.0 diopters or more;
2. Patients whose vision cannot be improved to at least $\frac{20}{40}$ with regular lenses but improvement of vision can be accomplished to $\frac{20}{40}$ or better; and
3. Replacement of a contact lens within two years is allowed only if there has been a significant change in basic lens parameters (design or prescription) prior authorization is required, see N.J.A.C. 10:62-2.5.

(g) The policy for duplication or reproduction of the same correction is as follows:

1. A re-examination and new prescription are required if more than one year (or two years in the case of an individual 19 through and including 59 years of age) has elapsed since the date of the original prescription.

(h) The New Jersey Medicaid program will not pay for replacement of optical appliances which may have been lost, broken, damaged or stolen unless prior authorized.

(i) Prior authorization is required for individuals with significant pathological conditions requiring optical tints other than rose, one and two, grey or brown plastic lenses 10 percent to 20 percent.

(j) Polycarbonate lenses may be provided in special situations when maximum protection is indicated and recommended in writing by the prescribing practitioner.

(k) Ultraviolet filter lens may be provided in special situations when maximum ultraviolet protection is indicated for the preservation of tissue integrity and recommended in writing by the prescribing practitioner.

(l) The following are not covered under the New Jersey Medicaid program:

1. Gradient tint;
2. Oversize lenses;
3. Photochromatic lenses;
4. Prescription sunglasses;
5. Rimless lenses; and
6. Temporary glasses.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.7 Standards and policies regarding frames

(a) Plastic, non-flammable frames acceptable to the New Jersey Medicaid program shall meet the following minimum criteria:

1. The manufacturer's name and the size of the frame shall be properly identifiable on the frame;

2. The temples shall be wire-reinforced;
3. A hinge rivet shall pass through the reinforcing temple wire;
4. The material shall contain no scratches, fissures or bubbles;
5. There shall be no material discoloration at the time of dispensing; and
6. The frame shall not be expanded beyond 1 millimeter of the original size when the lenses are inserted.

(b) Wire-metal frames are not covered under the New Jersey Medicaid program.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.8 Standards regarding guaranty/warranty

All rights, benefits, and services applicable to a private patient shall apply to the same extent to the Medicaid recipient.

10:62-2.9 Ocular prostheses

Artificial eyes and intraocular lenses, stock or custom-made, shall be of plastic material.

10:62-2.10 Approved fabricating laboratory

(a) For purposes of the New Jersey Medicaid program, an approved fabricating laboratory shall have the necessary equipment, licensed personnel and capability to completely surface and finish new optical glass or plastic lenses or partially finished lenses.

(b) The laboratory shall be able to provide all services necessary to completely furnish eyeglasses as may be requested by an optical dispenser and is subject to approval by the New Jersey Medicaid program. A provider may call the Vision Care Unit (609-588-2729) to ascertain if a laboratory is Medicaid approved.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.11 Recordkeeping policies

(a) Providers shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services, which are subject to post audit review. Such information shall be readily available to the representatives of the New Jersey Medicaid program or its agents as required.

(b) The records as required by (a) above shall include the following:

1. Name of the recipient;
2. Address of the recipient;
3. HSP (Medicaid) Case number;

4. Original prescription;
5. Date of the prescription received;
6. Date of the dispensing to the recipient;
7. Invoice from fabricating laboratory and material purchase invoices, as applicable; and
8. All supportive statements and reports, for example fire report, police report, developmental disabilities, medical necessity, etc.

(c) Records shall be kept and maintained by the provider for a period of at least five years from the date the service was rendered.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.12 Reimbursement policy

(a) Instructions for submitting claims for payment of optical appliances are provided in the Fiscal Agent Billing Supplement.

(b) Optical appliances must be identified by means of procedure codes, utilizing the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

(c) The reimbursement policy of the New Jersey Medicaid program provides for payment to the provider of the actual invoice cost of the optical appliance plus a dispensing fee. Providers are requested to indicate the actual invoice cost of the material when submitting a claim. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. The service (dispensing) fee, to which the provider is entitled, should be indicated as a separate item.

(d) The maximum allowable reimbursement for frames is not to exceed an allowance determined to be reasonable by the Commissioner, Department of Human Services. However, providers shall only bill the New Jersey Medicaid program for the actual invoice cost of the frame when submitting a claim for payment. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. Frames are reimbursable only if they meet the criteria listed in N.J.A.C. 10:62-2.7.

(e) Optical appliances are reimbursable under the New Jersey Medicaid program only when prescribed by a provider of professional eye services as defined in N.J.A.C. 10:62-1.3.

(f) Non-physician services and equipment/supplies furnished to hospital inpatients by outside providers shall not be billed directly to the New Jersey Medicaid program.

Providers shall submit a bill/invoice to the hospital for payment.

(g) The cost of intraocular lenses is reimbursable to hospitals or ambulatory surgical centers where the surgery is performed or directly to the ophthalmologist.

1. Ophthalmologists may be reimbursed for the cost of the intraocular lenses, provided that reimbursement is not requested by the hospital or the ambulatory surgical center. To be reimbursed, the ophthalmologist shall complete the MC-9 form and mail it to the fiscal agent.

(h) Reimbursement by the New Jersey Medicaid program shall be made for covered services provided to eligible recipients only.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:62-3.1 Introduction

(a) The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (Narratives found in CPT-4): These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narrative for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4, which is incorporated herein by reference, as amended and supplemented. (The CPT-4 is available from the Order Department of the American Medical Association, P.O. Box 109050, Chicago, Illinois 60610.)

2. Level II Codes (Narratives found in N.J.A.C. 10:62-3.5): These codes are assigned by HCFA for physician and non-physician services which are not in CPT-4.

3. Level III Codes (Narratives found in N.J.A.C. 10:62-3.3 and 3.5): These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

(b) The HCPCS procedure codes listed in this subchapter are divided into two sections: HCPCS procedure codes for professional services are in N.J.A.C. 10:62-3.2; and HCPCS procedure codes for vision care appliances are in N.J.A.C. 10:62-3.5.

(c) The responsibility of the provider when rendering professional services and requesting reimbursement is listed in N.J.A.C. 10:62-1 (Reimbursement Policies); for optical appliances, N.J.A.C. 10:62-2 (Reimbursement Policies).

1. When filing a claim, the appropriate HCPCS procedure codes must be used in conjunction with the modifiers when applicable.

2. The use of a HCPCS procedure code will be interpreted by the New Jersey Medicaid program as evidence that the practitioner personally furnished, at a minimum, the service which the code represents.

3. For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the practitioner submitting the claim:

i. Office, hospital, nursing home, or residential health care facility visits; and

ii. Any and all parts of a history or eye examination.

4. To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record must contain the practitioner's notes indicating that he/she personally:

i. Reviewed the patient's medical history with the patient and/or his/her family, depending upon the medical situation;

ii. Performed an eye examination;

iii. Confirmed or revised the diagnosis; and

iv. Visited and examined the patient on the day(s) for which a claim for reimbursement is made.

5. Date(s) of service(s) must be indicated on the claim form and in the practitioner's own record for each service billed.

6. When submitting a claim, the practitioner must always use his/her usual and customary fee. The Medicaid dollar value designated for the HCPCS procedure codes represents the New Jersey Medicaid program's maximum payment for the given procedure.

i. All references to time parameters shall mean the practitioner's time in reference to the service rendered unless it is otherwise indicated.

(d) Regarding specific elements of HCPCS procedure codes which require attention of providers, the lists of HCPCS procedure codes for vision care services are arranged in tabular form with specific information for a code identified under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", AND "MAXIMUM FEE ALLOWANCE". The information identified under each column is summarized below:

Column Title	
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer a provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure and service code is used. Explanation of indicators and qualifiers used in this column are identified below: "L" preceding any HCPCS procedure code indicates that the complete narrative for the HCPCS procedure code is located in N.J.A.C. 10:62-3.3. "N" preceding any HCPCS procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by HCPCS procedure code in N.J.A.C. 10:62-3.4. "P" preceding any HCPCS procedure code indicates that prior authorization is required. (See N.J.A.C. 10:62-1. and 2.) "R" preceding any HCPCS procedure code indicates a HCPCS procedure code for a factor necessary in the fabrication of a lens prescription. For proper reimbursement, the code must be listed on the claim form (MC-9) in addition to the basic lens code.
HCPCS CODE	Lists the HCPCS procedure code for professional services and vision care appliances.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the HCPCS procedure code. The New Jersey Medicaid program's recognized modifier codes for vision care services are as follows:
Modifier Code	Description
YF	Optical Frame Service Fee: To be used when patient supplies his or her own Medicaid plastic frame.
22	Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure code and enclose a copy of the invoice. When billing, a copy of the invoice is required. (See "Comprehensive Eye Examination with Diagnostic Fields" in N.J.A.C. 10:62-3.4.)
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier "52" signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic services. This also applies when using Stock Bifocals. (See "Bifocal Lenses, Glass or Plastic" in N.J.A.C. 10:62-3.5(d)).
MAXIMUM FEE ALLOWANCE	Lists New Jersey Medicaid program's maximum reimbursement schedule. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that the service is not reimbursable.

(e) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS

coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because, in certain instances, requirements are created in addition to the narrative which accompanies the HCPCS procedure code as written in CPT-4. The provider must be careful to enter the additional requirements, and not just the HCPCS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the HCPCS procedure code narrative prevails.

(f) For surgical codes relevant to Ophthalmologists see Physicians Services Chapter (N.J.A.C. 10:54-4, HCFA Common Procedure Coding System).

10:62-3.2 HCPCS Procedure Codes and maximum fee schedule for professional vision care services

Ind	HCPCS Code	Mod	Maximum Fee Allowance
	65205		\$16.00
	65210		32.00
	65220		32.00
	65222		48.00
	65430		16.00
	67820		16.00
	68800		8.00
N	92002		22.00
N	92004		22.00
N	92004	22	26.00
N	92012		22.00
N	92014		22.00
N	92014	22	26.00
	92018		35.00
	92019		35.00
N	92020		16.00
	92060		N.A.
P-N	92065		16.00
	92070		N.A.
N	92081		16.00
N	92082		16.00
N	92083		16.00
N	92100		16.00
N	92120		16.00
N	92130		16.00
N	92140		16.00
	92225		25.00
	92226		21.00
	92235		53.00
	92250		10.00
N	92260		15.00
	92265		25.00
	92270		11.00
	92275		20.00
N	92280		45.00
	92286		12.00
	92310		N.A.
	92311		N.A.
	92312		N.A.
	92313		N.A.
	92314		N.A.

Ind	HCPCS Code	Mod	Maximum Fee Allowance
	92315		N.A.
	92316		N.A.
	92317		N.A.
	92325		N.A.
	92326		70.00
	92330		N.A.
	92335		N.A.
	92340		N.A.
	92341		N.A.
	92342		N.A.
	92352		N.A.
	92353		N.A.
	92354		N.A.
	92355		N.A.
	92358		N.A.
	92370		N.A.
	92371		N.A.
	92541		5.00
	92542		8.00
	92544		5.00
	92545		5.00
N	99201		16.00
N	99202		16.00
N	99211		16.00
N	99212		16.00
N	99213		16.00
N	99214		16.00
N	99215		16.00
L	W9200		12.00
L-P	W9205		70.00
L-P	W9210		70.00
L-N	W9220		16.00

10:62-3.3 Professional vision care service codes and narratives not found in CPT-4 (Level II and Level III codes)

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance
	W9200		Low Vision Exam, a continuation of a comprehensive eye exam, with limited additional tests to determine if low vision devices would benefit vision problems that cannot be normalized by conventional spectacles. NOTE: This low vision examination is used as an additional procedure at the time of the original examination.	\$ 12.00
P	W9205		Low Vision Work-up with written report. Prior Authorization required. This is a battery of extensive tests and independent procedures to determine a device or a combination of devices that would permit an individual to enhance visual functions.	70.00
P	W9210		Vision training workup and written report (prior authorization required).	70.00
N	W9220		Slit lamp examination	16.00

10:62-3.4 Qualifiers for professional vision care services

(a) Qualifiers for professional vision care services are summarized below:

HCPCS Codes Procedure

1. COMPREHENSIVE EYE EXAMINATION

92002 Comprehensive Eye Examination—Codes 92002, 92004, 92012 or 92004 refer to a new or established patient respectively. For reimbursement purposes, the use of these codes requires as a minimum a comprehensive eye examination, one or more office visits, which shall include, with or without cycloplegics, and with or without a post cycloplegic visit, the following:

- Detailed case history;
- External and internal (ophthalmoscopic) examination;

HCPCS Codes Procedure

- Refraction (objective and subjective);
- Gross visual fields (central and peripheral);
- Tonometry (when indicated for patients under 35; mandatory for all patients over 35). The specific method used should be identified (that is, the finger palpation test is not acceptable);
- Binocular coordination testing (distance and near);
- The diagnosis (Ocular deficiency or deformity, visual or muscular anomaly, and so forth); and
- Recommendations.

2. COMPREHENSIVE EYE EXAMINATION WITH DIAGNOSTIC FIELDS

92004 22 Comprehensive Eye Examination with Diagnostic Fields—Codes 92004 22 or 92014 22 refer to a new or established patient respectively. For reimbursement purposes, it shall include all the criteria of procedure codes 92002, 92004, 92012 or 92014 plus complete Diagnostic Visual Fields.

- NOTE: These codes are not routinely reimbursable for complete comprehensive eye examination. Patients should be selected for this additional service based upon history and ophthalmologic findings during the examination; if the physical examination suggests the presence of optic or motor nerve abnormalities, or if other significant physical findings are present and documented, diagnostic visual field studies may be selectively employed to establish or to confirm the diagnosis and/or the degree of impairment.
- NOTE: A Comprehensive eye examination with or without diagnostic fields is limited to once a year.

3. INDEPENDENT OFFICE PROCEDURES

92020 Independent Office Procedures—Codes 92020, 92065, 92081, 92082, 92083, 92100, 92120, 92130, 92140, 92260, W9220, are not reimbursable when performed on the same day as Codes 99201, 99202, 99211, 99212, 99213, 99214, 99215, 92002, 92004, 92012 or 92014. When multiple procedures are billed on the same day for the same patient in an office setting, reimbursement will be limited to the highest valued procedure.

92100
92120
92130
92140
92260
W9220

4. OFFICE SERVICES (NEW PATIENT)

99201 Codes 99201 and 99202 are not reimbursable with 92002, 92004, 99202 or 92014 on the same day.

5. OFFICE SERVICES (ESTABLISHED PATIENT)

99211 Codes 99211, 99212, 99213, 99214, and 99215 are not reimbursable with 92002, 92004, 92012 or 92014 on the same day.

99212
99213
99214
99215

6. BRAIN-STEM-EVOKED RESPONSE TESTING

92280 Not reimbursable for initial testing, general screening, research studies or any situation where usefulness has not been clearly established; and therefore, it is without controversy.
Code 92280—for reimbursement purposes refers to a visual brain-stem-evoked response (VBR) with interpretation. Reimbursable to hospital outpatient department as a hospital charge or to a qualified provider (office setting). The study must be personally performed by any of the following disciplines trained and experienced with VBR testing, namely Ophthalmologists, Optometrists, Neurologists, Neurosurgeons, and Psychiatrists. Criteria for testing:

- Inconclusive test results by standard vision testing for:
 - Neonates and infants at risk for vision loss;
 - Children and adults who cannot perform behavioral testing.
- Suspected organic neurologic lesion within or proximal to the visual pathway.

10:62-3.5 HCPCS Procedure Codes and maximum fee schedule for vision care appliances

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance
(a)	Y5100		Lens Service (Cataract Bifocal over + or - 10 D)	\$ 40.00

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance	Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance	
	Y5105		Lens Service (Cataract Single Vision over + or - 10 D)	20.00		V2203		Sphero-cylinder, bifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens	13.50	
	Y5110		Lens Service (Single vision lens)	12.00		V2204		Sphero-cylinder, bifocal, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens	14.50	
	Y5112		Lens Service (Bifocal lens)	15.00		V2205		Sphero-cylinder, bifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens	15.50	
	Y5114		Lens Service (Trifocal lens)	17.00		P V2206		Sphero-cylinder, bifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens	B.R.	
(b) FRAMES						V2207		Sphero-cylinder, bifocal plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	18.60	
	V2020		Frames, purchases	8.00		V2208		Sphero-cylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens	20.65	
	Y5150		Frames, purchase, replacement (due to irreparable damage)	8.00		V2209		Sphero-cylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	21.65	
	Y9787		Repair of frames NOTE: Frame repairs charge \$15.00 or more require prior authorization	15.00	P	V2210		Sphero-cylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens	B.R.	
	Y5165		Frames, (dispensing fee)	8.00		V2211		Sphero-cylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.00D cylinder, per lens	23.60	
	Y5165	YF	Frames, (dispensing fee) NOTE: YF—Patient supplied his or her own Medicaid plastic frame	8.00		V2212		Sphero-cylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens	25.60	
(c) SINGLE VISION LENSES, GLASS OR PLASTIC						V2213		Sphero-cylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25D to 4.00D cylinder, per lens	25.60	
	V2100		Sphere, single vision, plano to plus or minus 4.00, per lens	5.80		V2214		Sphero-cylinder, bifocal, sphere over plus or minus 12.00D, per lens NOTE: With any cylinder	25.60	
	V2101		Sphere, single vision, plus or minus 4.12 to plus or minus 7.00D, per lens	6.00	R	V2215		Lenticular (myodisc), per lens, bifocal	40.00	
	V2102		Sphere, single vision, plus or minus 7.12 to plus or minus 20.00D, per lens	14.25	R	V2216		Lenticular, nonaspheric, per lens, bifocal	55.00	
	V2103		Sphero-cylinder, single vision, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens	8.50	R	V2217		Lenticular, aspheric, per lens, bifocal	65.00	
	V2104		Sphero-cylinder, single vision, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens	9.50	P	V2218		Aniseikonia, per lens, bifocal	B.R.	
	V2105		Sphero-cylinder, single vision, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens	10.50	P	V2219		Bifocal seg width over 28mm	B.R.	
P	V2106		Sphero-cylinder, single vision, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens	B.R.	P	V2220		Bifocal add over 3.25D	15.00	
	V2107		Sphero-cylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	10.50	P	V2299		Specialty bifocal	B.R.	
	V2108		Sphero-cylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, 2.12D to 4.00D cylinder, per lens	11.50	(e) TRIFOVAL LENSES, GLASS OR PLASTIC (up to and including 28mm seg width, add power up to and including 3.25D)					
	V2109		Sphero-cylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	12.50	V2300			Sphere, trifocal, plano to plus or minus 4.00D, per lens	19.50	
P	V2110		Sphero-cylinder, single vision, plus or minus 4.25 to 7.00D sphere, over 6.00D cylinder, per lens	B.R.	V2301			Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00D, per lens	21.75	
	V2111		Sphero-cylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens	13.50	V2302			Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	26.35	
	V2112		Sphero-cylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder, per lens	14.50	V2303			Sphero-cylinder, trifocal, plano to plus or minus 4.00D sphere, .12-2.00D cylinder per lens	21.00	
	V2113		Sphero-cylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens	15.50	V2304			Sphero-cylinder, trifocal, plano to plus or minus 4.00D sphere, 2.25 to 4.00D cylinder, per lens	22.00	
	V2114		Sphero-cylinder, single vision, sphere over plus or minus 12.00D, per lens NOTE: With any cylinder	19.50	V2305			Sphero-cylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00 cylinder, per lens	23.00	
R	V2115		Lenticular, (myodisc), per lens, single vision	25.00	V2306			Sphero-cylinder, trifocal, plano to plus or minus 4.00D sphere, over 6.00 cylinder, per lens	30.00	
R	V2116		Lenticular lens, nonaspheric, per lens, single vision	35.00	P	V2307		Sphero-cylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	B.R.	
R	V2117		Lenticular, aspheric, per lens, single vision	45.00	P	V2308		Sphero-cylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens	B.R.	
P	V2118		Aniseikonia lens, single vision	B.R.	P	V2309		Sphero-cylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	B.R.	
P	V2199		Not otherwise classified, single vision lens	B.R.	P	V2310		Sphero-cylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens	B.R.	
(d) BIFOVAL LENSES, GLASS OR PLASTIC (up to and including 28mm seg width, add power up to and including + 4.00D)						P	V2311		Sphero-cylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens	B.R.
	V2200		Sphere, bifocal, plano to plus or minus 4.00D per lens	12.00						
	V2200	52	Sphere, bifocal, plano to plus or minus 4.00D, per lens—Stock lens	7.00						
	V2201		Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D per lens	14.25						
	V2201	52	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D per lens—Stock lens	7.00						
	V2202		Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00D, per lens	18.85						

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance
P	V2312		Sphero-cylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens	B.R.
P	V2313		Sphero-cylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens	B.R.
P	V2314		Sphero-cylinder, trifocal, sphere over plus or minus 12.00D cylinder, per lens NOTE: With any cylinder	B.R.
P-R	V2315		Lenticular, (myodisc), per lens, trifocal	B.R.
P-R	V2316		Lenticular nonaspheric, per lens, trifocal	B.R.
P-R	V2317		Lenticular, aspheric, per lens, trifocal	B.R.
P	V2318		Aniseikonia, per lens, trifocal	B.R.
P	V2319		Trifocal seg width over 28mm	B.R.
	V2320		Trifocal add over 3.25D NOTE: Per pair	15.00
P	V2399		Specialty trifocal	B.R.
(f) VARIABLE SPHERICITY LENSES (Welsh 4 drop, hyperaspheric, double drop, etc.)				
P	V2410		Variable sphericity lens, single vision, full field, glass or plastic, per lens	B.R.
P	V2430		Variable sphericity lens, bifocal, full field, glass or plastic, per lens	B.R.
P	V2499		Variable sphericity lens, other type	B.R.
(g) CONTACT LENSES				
P	V2500		Contact lens, pmma, spherical, per lens	B.R.
P	V2501		Contact lens, pmma, toric or prism ballast, per lens	B.R.
P	V2502		Contact lens, pmma, bifocal, per lens	B.R.
P	V2503		Contact lens, pmma, color vision deficiency, per lens	B.R.
	V2510		Contact lens, gas permeable, spherical, per lens	120.00
P	V2511		Contact lens, gas permeable, toric, prism ballast, per lens	B.R.
P	V2512		Contact lens, gas permeable, bifocal, per lens	B.R.
	V2513		Contact lens, gas permeable, extended wear, per lens	120.00
	V2520		Contact lens hydrophilic, spherical, per lens	100.00
P	V2521		Contact lens hydrophilic, toric, or prism ballast, per lens	B.R.
P	V2522		Contact lens hydrophilic, bifocal, per lens	B.R.
	V2523		Contact lens hydrophilic, extended wear, per lens	100.00
P	V2530		Contact lens, scleral, per lens (for contact lens modification, see 92325)	B.R.
P	V2599		Contact lens, other type	B.R.
(h) LOW VISION AIDS				
	V2600		Hand held low vision aids and other nonspectacle mounted aids	75.00
	V2610		Single lens spectacle mounted low vision aids	150.00
P	V2615		Telescopic and other compound lens system including distance vision telescopic, near vision telescopic and compound telescopic lens system	B.R.
(i) PROSTHETIC EYES				
P	V2620		Prosthetic, eye, glass, stock	B.R.
	V2621		Prosthetic, eye, plastic, stock	300.00
P	V2622		Prosthetic, eye, glass, custom	B.R.
	V2623		Prosthetic, eye, plastic, custom	300.00
P	V2629		Not otherwise classified, prosthetic eye	B.R.

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance
(j) INTRAOCULAR LENSES				
	V2630		Anterior chamber intraocular lens	200.00
	V2631		Iris supported intraocular lens	200.00
	V2632		Posterior chamber intraocular lens	200.00
(k) MISCELLANEOUS				
	V2700		Balance lens, per lens	5.00
	V2700	22	NOTE: Single vision Balance lens, per lens	10.00
	V2710		NOTE: Bifocal Slab off prism, glass or plastic, per lens	B.R.
P	V2715		Prism, per lens	7.00
P	V2718		Press-on lens, Fresnell prism, per lens	B.R.
P	V2730		Special base curve, glass or plastic, per lens	B.R.
	V2740		Tint, plastic, rose 1 or 2, per lens	3.50
	V2741		NOTE: Per pair Tint, plastic, other than rose 1-2, per lens	3.50
	V2742		NOTE: Grey or Brown 10%-20% only, per pair Tint, glass rose 1 or 2, per lens	3.50
P	V2743		NOTE: Per pair Tint, glass other than rose 1 or 2, per lens	B.R.
	V2755		U.V.—Lens	10.00
	V2770		NOTE: Per Pair Occluder lens, per lens	10.00
	V2785		Processing, preserving and transporting corneal tissue	500.00
P	V2799		Vision service, miscellaneous	B.R.
P	Y5200		Vision training devices	B.R.
	Y5201		Polycarbonate lens	20.00
			NOTE: Per pair	

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

PARAMAX/UNISYS

CN-4801

Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law

Quakerbridge Plaza, Building 9

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