Vision Services

Reimbursement Policy ID: RPC.0102.72AC

Recent review date: 10/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses vision services, eyeglass frames, lenses, and contact lenses.

Exceptions

Participants with a diagnosis of aphakia or cataracts may be eligible for eye wear (glasses or contacts).

Reimbursement Guidelines

Routine examinations are covered services and therefore eligible for reimbursement for certain members two times each calendar year. The health plan does not cover prescription eyeglasses or prescription contact lenses.

Extended ophthalmoscopy with a retinal/optic nerve drawing, (unilateral or bilateral) (92201-92202) is non-covered when billed with fundus photography (92250) or a with fluorescein angiography (92235). An extended ophthalmoscopy with a retinal/optic nerve drawing, (unilateral or bilateral) will not be reimbursed without a diagnosis of disorders of the globe, choroid, retina, iris and ciliary body, or glaucoma.

Lenses
Lenses are not covered by the plan.

Contacts
Contact lenses are not covered by the plan.

Definitions

Extended ophthalmoscopy
The method of examining the posterior portion of the eye when the level of examination requires a complete view of the back of the eye and documentation is greater than that required during routine ophthalmoscopy.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. Applicable provider Manual.
IV. Applicable Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

10/2026	Reimbursement Policy Committee Approval