Vision Services

Reimbursement Policy ID: RPC.0102.7700

Recent review date: 09/2025

Next review date: 12/2026

AmeriHealth Caritas Ohio 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. AmeriHealth Caritas Ohio 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

Members 21 years or older with a diagnosis of aphakia or cataracts, and some members with diabetes, may be eligible for eye wear (glasses or contacts).

Reimbursement Guidelines

Routine eye examinations are covered services and therefore eligible for reimbursement by AmeriHealth Caritas Ohio for certain members every 12-24 months depending on patient age or diagnosis of diabetes. Members under 21 and over 65 are eligible for 1 pair of prescription eyeglasses every 12 months. Members 21 years of age and older are eligible for 1 pair of prescription eyeglasses every 24 months.

Service	Members under 21 Years of Age/65 and Older	Members 21-64 Years of Age	Members with Diabetes
Eye Exams	1 routine eye exam every 12 months	1 routine eye exams every 24 months	2 every 12 months
Eyeglasses (frames) (V2020)	1 pair eyeglass frames every 12 months.	1 pair of eyeglass frames every 24 months	1 frame every 24 months, adjustment to lenses as needed per year
Lenses	1 pair of standard lenses every 12 months	1 pair of standard lenses every 24 months	Lenses once every 24 months, adjustment to lenses as needed per year
Contact Lenses	Prior authorization required	Prior authorization required	Prior authorization required

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
Reimbursement of V2100 (sphere, single version, plano to plus or minus 4.00, per lens) and V2101 (sphere, single vision, plus or minus 4.12 to plus or minus 7.00D, per lens), is limited to once in a 12-month period for children under 21 and adults over 65. Lenses are reimbursed once every 24 months for patients aged 21-64 and for patients with diabetes.

Contacts
Prior authorization is required for use of contact lenses.

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. https://www.amerihealthcaritasoh.com/assets/pdf/provider/vision-benefits.pdf
IV. Ohio Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

09/2025	Reimbursement Policy Committee Approval
08/2025	Annual Review • No updates
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
12/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Ohio from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section