Determination of refractive state

Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ **Medicare Plus Blue℠ PPO** ☐ **Medicare Plus Blue℠ Group PPO** ☒ **Both**

Determination of refractive state

Determination of the refractive state is necessary for obtaining glasses and includes specification of lens type (monofocal, bifocal, other), lens power, axis, prism, absorptive factor, impact resistance and other factors.

Original Medicare

Under Original Medicare, determination of refractive state is statutorily excluded from coverage. No payment may be made under Part A or Part B for any expenses incurred for items or services when such expenses are for routine physical checkups, eyeglasses [other than eyewear described in section 1861(s) (8)] or eye examinations for the purpose of prescribing, fitting or changing eyeglasses, or procedures performed during the course of any eye examination to determine the refractive state of the eyes.

Expenses for all determination of refractive state procedures, whether performed by an ophthalmologist or any other physician or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

Medicare Plus Blue℠ PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program while adding desired benefit options.

Because Original Medicare doesn't cover determination of refractive state procedures, the scope of the benefit, reimbursement methodology, maximum allowed payment amounts, and member cost sharing are determined by Blue Cross for individual coverage and by the group for those with group–based coverage that includes this benefit.

Determination of refractive state procedures are covered only under these circumstances:

- A provider must identify the member's refractive state to determine an injury, illness or disease.
- An ophthalmologist or an optometrist must determine the refractive state for corrective lenses.
- The member's refractive state is determined as part of a surgical procedure.

Conditions for payment

This table below specifies payment conditions for determination of refractive state.

Conditions for payment	
Eligible providers	M.D., D.O., ophthalmologist or optometrist
Payable location	No restrictions
Frequency	No restrictions
CPT/HCPCS	92015
Diagnosis restrictions	No restrictions
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue plan's maximum payment amount for the determination of refractive state benefit is available on our provider website on the Medicare Plus Blue enhanced benefits fee schedule. The provider will be paid the lesser of this amount or the provider's charge, minus the member's cost share. This represents payment in full and providers aren't allowed to bill the member for the difference between the allowed amount and the charge.

Member cost sharing

- Medicare Plus Blue providers should, when possible, collect the applicable cost sharing from the member at the time of the service. Cost sharing refers to a flat dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue cost-sharing amounts from the member.
- If the member elects to receive noncovered service, he or she is responsible for the entire charge associated with that service.
- Providers may not have members sign an ABN to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item/service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost share.

To verify benefits and cost share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local Blue Cross plan.
6. Use electronic billing:
   a. Michigan providers:
      Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/ Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at: **bcbsm.com/providers/help/edi/**.
   b. Providers outside of Michigan should contact their local Blue Cross plan.

Additional billing instructions

1. Identify the member's refractive state to determine an injury, illness or disease.
   a. Evaluation and management codes: general ophthalmologist services, office or other outpatient services, office or other outpatient consultation and emergency department services must be billed along with 92015. Both are payable.
2. Determine the refractive state for corrective lenses.
   a. A routine ophthalmologist examination, which includes the refraction, must be billed.
   b. CPT code 92015 cannot be reported as a separate procedure code.
3. Determine if the member's refractive state is a part of the surgical procedure. For questions or help related to proper bill coding, call the EDI Help Desk at 1-800-542-0945 or email **realtimesupport@bcbsm.com**.
   a. The surgical procedure code must be billed.
   b. CPT code 92015 is considered incidental or mutually exclusive and cannot be reported.

Revision history

Policy number: MAPPO 1010

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Revised: 03/03/2025, 07/27/2015, 2012

03/03/2025: Removed diagnosis restrictions effective 06/28/2024.

07/27/2015: Updated formatting, web links, conditions for payment, billing instructions; removed CAREN reference, added revision history section.