Vision Services

Reimbursement Policy ID: RPC.0102.5420

Recent review date: 04/2026

Next review date: 12/2026

Healthy DC 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. Healthy DC 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.
All vision benefits/services go through the plan subcontractor - AVESIS. Routine vision care is not covered.

Exceptions

Healthy DC reimburses eye exam for beneficiaries 21 years of age or older are limited to the following:

- The services are medically necessary and required to monitor for a chronic condition that could harm
- a beneficiary's vision or an acute medical condition that could harm the beneficiary's vision.

Reimbursement Guidelines

Service	Members under 21 Years of Age	Members 21 +
Eye Exams	Eye exams at least once every year and as needed.	1 routine eye exams every calendar year for acute medical condition or chronic illness.
Eyeglasses (frames) (V2020)	1 pair of eyeglass frames every 2 years except when the member has lost their eyeglasses, or the prescription has changed by more than 0.5 diopter.	1 pair every 24 months unless replacement is needed due to breakage or loss.
Lenses	Eyeglasses (corrective lenses) every 2 years except when the member has lost their eyeglasses, or the prescription has changed more than 0.5 diopter.	1 pair every 24 months unless prescription changes or damage to current lenses.
Contact Lenses	Must be medically necessary.	2 boxes, 1 each eye, in a six-month period with prior authorization.

Eye exams are reimbursed at least once every year and as needed; and eyeglasses (corrective lenses) as needed. Members under the age of 21 are allowed one (1) pair of eyeglasses every two (2) years except when the member has lost their eyeglasses or when the prescription has changed by more than 0.5 diopter. Reimbursement for eyeglasses for members age 21 and older is limited to one pair of eyeglasses every 24 months unless replacement is needed due to breakage or loss.

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.

Contacts
Contact lenses may be reimbursed if optometrist or ophthalmologist identifies a medical need for members under 21. Contact lenses for members 21 years and over require prior authorization.
All vision benefits/services go through the plan subcontractor - AVESIS. Providers should call 1-855-704-0437.

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://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DG852345_KT0000009782_1_0.pdf
IV. Applicable District of Columbia Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

04/2026	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by Health DC 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