Optometry Coding & Billing Alert

Reader Question: 379.31 Proves Necessity for V2219

Question: I'm really confused about codes V2219 and V2319 for Medicare patients. I know it's an add-on code, but what kind of documentation do we need to prove medical necessity? I have a new optician who disagrees with the way we bill those two codes he insists that the prescription needs to specifically state that a segment greater than 28 mm is necessary for Medicare to pay.

Texas Subscriber

Answer: You should not need any additional documentation for V2219 (Bifocal seg width over 28mm) or V2319 (Trifocal seg width over 28mm) beyond what you need for refractive lenses in general. Medicare durable medical equipment regional carriers (DMERC) will not reimburse for refractive lenses unless the patient has had cataract surgery.

The ICD-9 code that proves medical necessity must be included on the claim. Cigna, the DMERC for Region C, which includes Texas, lists 379.31 (Aphakia), 743.35 (Congenital aphakia), and V43.1 (Organ or tissue replaced by other means; lens) as acceptable diagnoses.

Bill V2219 or V2319 in addition to the code for the basic lens (e.g., V2201, Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens). DMERCs will allow only one pair of glasses after each cataract surgery.

In Texas, Cigna will allow $47.45 for V2219 and $51.72 for V2319. If those amounts are less than what appears on your bill, the DMERC transfers the balance to the "patient responsibility" column if you appended modifier GA (Waiver of liability statement on file) to the V code.

Be sure to have the patient sign an advance beneficiary notice (ABN) before you submit the bill to the DMERC. This will free you to collect the unpaid Medicare allowable balance for the bifocal segs from the patient.