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2. Eye and Vision Services Provider

2.1. General Policy
This guideline covers all Medicaid vision services provided through Opticians, Optometrists, and Ophthalmologists as deemed appropriate by the Department of Health and Welfare (DHW). These specialties are identified as vision services throughout this document. This handbook details services that are currently reimbursable by Idaho Medicaid for both adults and children.

2.2. Participant Eligibility
Providers must always confirm eligibility on the date of service. Participants who are covered under a restricted program do not have vision benefits under Medicaid fee-for-service. These programs include, but are not limited to the following.
- Otherwise Ineligible Non-Citizens (OINC)
- Presumptive Eligibility (PE)
- Qualified Medicare Beneficiary (QMB) Program only, without another unrestricted Medicaid eligibility program open
- Medicare Medicaid Coordinated Plan (MMCP)

2.2.1. Limited Vision Eligibility
Participants under the age of 21 are eligible for the following.
- Examinations, vision testing, eyeglasses, and contact lenses are covered if Department criteria are met.
- Additional services are covered if medically necessary to correct or ameliorate defects.

Participants 21 years of age and older are eligible for the following.
- Examinations and vision testing necessary to monitor a chronic medical condition that may damage the eye.
- Services to treat acute conditions that, if left untreated, may cause permanent or chronic damage to the eye.
- Eyeglasses and contact lenses:
  - One pair of eyeglasses or contact lenses is covered following cataract surgery.
  - Contacts are covered to treat Keratoconus.
  - When necessary to prevent further degradation of vision, a contact lens or eyeglass prior authorization request with supporting documentation may be submitted for review.

Routine eye exams, eyeglasses, and contact lenses for the purpose of correcting nearsightedness, farsightedness, or astigmatism are not covered.

2.2.2. Low-Income Pregnant Women Program (PW)
Pregnant women of any age who are eligible through the PW Program are only eligible for pregnancy-related services. If the PW participant has a vision problem that has been caused by or is exacerbated by the pregnancy, then the eye exam and treatment are covered. Routine eye exams, eyeglasses, and contact lenses are not covered for women on the PW Program.
2.3. Reimbursement
Medicaid reimburses medically necessary vision services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

2.4. Medicare Crossovers for Vision Services
Participants may be dually eligible for Medicare and Medicaid. When a Medicaid participant has Medicare as primary, the provider must first bill Medicare for exam services and tests. A copy of the Medicare Remittance Notice (MRN) must be included with the Medicaid claim. If billing electronically, the information from Medicare must be entered on the appropriate screens. Classic Optical will bill Medicare for eyeglasses and contact lenses. In both cases, the claim will automatically crossover to Medicaid.

QMB Only: Participants that have Qualified Medicare Beneficiary (QMB) coverage only, are only eligible for Medicare covered services. Medicaid’s payment for services will be calculated according to the “Member Responsibility” methodology.

QMB Plus Medicaid: Participants who are covered by both QMB and another Medicaid program (dually eligible) are entitled to Medicaid Eye and Vision benefits.

MMCP: Participants who are covered by MMCP are dually eligible with Medicare and Medicaid and have chosen a Medicare Advantage Insurance Plan. These participants do not have Medicaid benefits for eye and/or vision services. Contact the participant's MMCP vision carrier for benefits.

See the General Billing Instructions, Coordination of Benefits (COB) regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount. Providers may only bill non-covered services to the participant if the provider has informed the participant of their responsibility to pay, preferably in writing, prior to rendering services.

2.4.1. Third Party Insurance Verification
If, after verification of third party information, or information from the participant, it is found that the Medicaid coverage information is not correct, the provider may notify Idaho Medicaid’s third party recovery contractor, HMS (Health Management Systems), at 1 (800) 873-5875, fax to 1 (208) 375-1134, or e-mail idtplinsurance@hms.com. HMS will verify information and update the Medicaid file, if necessary. Medicaid insurance coverage codes do not distinguish between eye exams and glasses or contacts. If only eye exams are a benefit, an Explanation of Benefits (EOB) is still required showing glasses or contacts are not covered.

2.4.2. Third Party Insurance Billing
Idaho Medicaid covers frames, conventional lenses, and contact lenses only when provided by the Medicaid contractor, Classical Optical. Medicaid is the payer of last resort. If a Medicaid participant has other insurance for vision services, then the other insurance must be billed prior to billing Medicaid.

Some insurance companies utilize alternate providers of vision hardware. In those cases the participant must choose between the Medicaid product and the non-Medicaid product. Medicaid reimbursement is dependent on the participant's choice of the following.
- The Medicaid contract product - there is no additional cost to the participant.
- A non-Medicaid contract product - the vision hardware is not reimbursable by Medicaid.

Providers may bill participants for the portion not covered by the non-Medicaid contract provider if the participant has agreed to be responsible for payment prior to ordering. In those cases, the provider may wish to obtain a written agreement from the responsible party.

Other insurance companies do not specify where their participants obtain their vision hardware. For those companies Idaho Medicaid does not require an explanation of benefits to be submitted for vision supplies ordered from Medicaid’s vision products contractor.

**Classic Optical** will deliver the requested supplies and bill the third party insurance.

### 2.5. Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho’s Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled in the HC Program, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services. See **General Provider and Participant Information** for more information.

Vision services performed in the offices of ophthalmologists and optometrists, including the dispensing of eyeglasses, do not require a HC referral. Procedures performed in an inpatient or outpatient hospital or ambulatory surgery center setting require a referral. The PCP should perform the pre-operative exam whenever possible or a referral will be necessary.

### 2.6. Vision Service Policy

This section defines Medicaid’s vision services and limitations.

#### 2.6.1. Covered Vision Services


Refer to the **CMS 1500 Instructions** for the CMS 1500 form, which contains a list of codes representing the services covered by Idaho Medicaid. This document is found in the Provider Handbook, under the **Claim Form Instructions** section.

Idaho Medicaid reimbursement rate for the routine exam includes determination of refraction state.

#### 2.6.2. Vision Exams

Idaho Medicaid requires the appropriate eye exam procedure code to be billed for routine eye exams. Evaluation and management procedures are paid only in the case of an eye injury or disease.

Instrument-based ocular screening (photoscreening) may be used as part of a vision exam, but is not separately reimbursable. It is only billable by a physician or mid-level provider (advanced practice professional nurse or physician assistant).
2.6.2.1. Intermediate Ophthalmological Services

Intermediate Ophthalmological Services include medical examination and evaluation, with initiation or continuation of diagnostic and treatment program. This includes following.

- Medical history review.
- General medical observations.
- External ocular and adnexal examination.
- Other diagnostic procedures like ophthalmoscopy, biomicroscopy, or tonometry may be done, along with a treatment regimen.
- Visit may include mydriasis.

The participant does not require a comprehensive service for a routine eye exam or is being examined for a chronic, but stable, condition (i.e., known cataract).

2.6.2.2. Comprehensive Ophthalmological Services

A comprehensive visual examination includes the following professional and technical vision services.

- Complete visual system examination
- Medical history review
- General medical observation
- External and ophthalmoscopic examination.
- Determination of best-corrected visual acuity
- Gross visual fields
- Basic sensorimotor examination with cycloplegia or mydriasis
- Tonometry
- Refractive state
- Initiation of diagnostic and treatment programs
- Other examination techniques that may be included in the fee for the comprehensive exam are:
  - Retinoscopy
  - Keratometry
  - Slit lamp viewing, tear testing
  - Corneal staining
  - Corneal sensitivity
  - Fundus examination
  - Treatment programs

2.6.2.3. New Patient Exam

A new patient is one who has not received any professional services for the last three years from the physician or another physician of the same specialty who belongs to the same group practice.

2.6.2.4. Established Patient Exams

An established patient is one who has received professional services for the last three years from the physician or another physician of the same specialty who belongs to the same group practice.

2.6.2.5. Refraction Procedure

See 2.6.3.2 Service Limitations for Eye Exams for limitations related to exams. Medicaid’s reimbursement rate for exams includes determination of refractive state and should be part of every intermediate or comprehensive exam. The Department will not pay for an exam code and refraction code billed for the same date of service.
For participants under the age of 21, providers may bill a refraction (CPT 92015) without the exam. Determination of refractive state includes specification of lens type, lens power, axis, prism, absorptive factor, impact resistance, interpupillary distance and other necessary factors.

2.6.2.6. **Special Ophthalmological Services**

Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given. Interpretation and report by the provider is an integral part of special ophthalmological services.

The following procedures do not need prior authorization.

- Slit lamp examination
- Keratometry
- Routine ophthalmoscopy
- Retinoscopy
- Refractometry
- Tonometry
- Biomicroscopy
- Examination with cycloplegia or mydriasis
- Motor evaluation

2.6.3. **Fitting Fee/Dispensing Fee**

Fitting or dispensing of glasses does not require prior authorization. The dispensing provider may bill for fitting/dispensing when:

- The participant receives new frames or lenses that are reimbursed by Medicaid.
- They are ordered from the Medicaid Contractor.

2.6.3.1. **Evaluation and Management**

Evaluation and Management (E/M) Codes are used to report services provided in the physician’s office related to eye injury or diseases affecting the eye. These codes do not require a PA. See the Current Procedural Terminology (CPT) codebook for definitions and guidelines for the appropriate use of these codes.

2.6.3.2. **Service Limitations for Eye Exams**

**Participants under Age 21**

Medicaid covers one complete visual examination annually (365 days) to determine the need for glasses. Exams earlier than 365 days require PA.

**Participants Age 21 and Over**

If the participant is 21 years of age and older, the participant is eligible for the following.

- Examinations and vision testing necessary to monitor a chronic medical condition that may damage the eye.
- Services to treat acute conditions that, if left untreated, may cause permanent or chronic damage to the eye.

A KX modifier is not required when billed with a diagnosis on the Vision Chronic or Acute Condition Diagnosis Codes list in the Vision Services Policy.
A KX modifier must be used if an examination does not pertain to a diagnosis on the Vision Chronic or Acute Condition Diagnosis Codes list in the Vision Services Policy. Supporting medical documentation is required and must be attached to the claim. These claims undergo medical review.

2.6.4. Vision Contractor and Supplies

All vision supplies (frames, lenses, contact lenses) must be ordered from Classic Optical, the Medicaid contractor, who will bill Medicaid for the supplies. Supplies obtained through any other lab will not be reimbursed by Medicaid.

Contractor contact information: Classic Optical Laboratories, Inc.

View and order from the Classic Optical catalog online at http://www.classicoptical.com, or fax orders to 1 (888) 522-2022. Providers who do not have access to the internet or fax service can mail eyeglasses and contact lens orders to the following address.

Classic Optical Laboratories, Inc. Phone 1 (888) 522-2020
3710 Belmont Avenue
Youngstown, OH 44505

Idaho Medicaid is requiring providers to select the most appropriate diagnosis code when placing an order on the Classic Optical website. There will be a dropdown menu with diagnoses code to select.

2.6.5. Lenses and Frames

Some lenses and specialty frames require prior authorization; please refer to 2.6.6 Prior Authorization.

2.6.5.1. Participants under Age 21

The Department will purchase one frame and one set of single vision or bifocal lenses once every four (4) years (IDAPA 16.03.09.782.03) unless there is a major vision change. Criteria within Early Periodic Screening, Diagnosis and Treatment services (EPSDT) allows for more frequent coverage. Initial pair of eyeglasses must have a minimum Rx of 0.50 diopter in at least one eye (considering both the spherical and cylindrical prescription).

Replacement Eyeglass Lenses

The Department will purchase new lenses, and the order may be placed directly with Classic Optical when:

- It has been more than four years since the participant has received lenses.
- There is a documented major visual change that is equal to or greater than plus or minus 0.50 diopter in one eye (considering both the spherical and cylindrical prescription) and the lens type does not require prior authorization.
- It has been less than four years since the child received lenses (EPSDT), and the lenses have been lost, damaged beyond use, or the current frames have been outgrown.

Replacement Frames

The Department will provide frames, and the order may be placed directly with Classic Optical when:
• It has been four years since they have received frames.
• There is a documented major change in visual acuity and the prescription cannot be accommodated in lenses which fit the existing frames.
• The glasses are lost, damaged, or outgrown, and it has been less than four years since they have received frames (EPSDT).
• The lenses for the frame do not require a prior authorization based upon the prescription.

**Note:** If a participant has a history of repeatedly breaking frames, the vision provider is asked to either repair the frame, or request a sturdier frame (V2020). Specialty frames are not considered medically necessary in cases of repeated breakage of frames.

**Replacement or Repairs**
They will replace frames which break due to normal wear in the first 90 days. If repairs are needed after 90 days, the provider may bill Medicaid for the repairs using CPT code 92370.

### 2.6.5.2. Participants 21 Years and Older
If a participant has Medicare primary and meets the criteria below authorization is not required for glasses. The order must include the date of cataract surgery, eye(s) treated, and the surgeon’s name.
- One pair of eyeglasses following recent cataract surgery. The Department follows the Medicare Coverage Determination Guidelines for cataract surgery.
- If the participant has Medicare primary, Classic Optical will bill Medicare for eyeglasses.

### 2.6.6. Prior Authorization (PA)
Prior authorizations are valid beginning the date they are received in the Medical Care Unit, and are valid for two months from the date of authorization. A copy of the Vision Prior Authorization Request Form or the Contact Lens Prior Authorization Request Form is available on the Medical Care Unit’s Vision Services website.

Fax requests are preferred. Send the fax to 1 (877) 314-8779. The request form for each participant must be received as a separate fax. Do not combine documents for more than one participant in one fax submission. Please complete all pertinent sections of the request form. The HCPCS codes authorized by Medicaid must match the order placed on the Classic Optical Order Form.

If no fax is available, mail requests to the following address.

Division of Medicaid
Vision Services Prior Authorization
PO Box 83720
Boise, ID 83720-0009

Providers can view the outcome of the review through their Trading Partner Account online at [www.idmedicaid.com](http://www.idmedicaid.com) by clicking **Authorization Status** under Form Entry.

All claims submitted or adjusted on or after May 1, 2014 for services that require a prior authorization, will be denied if the PA number is not on the appropriate claim line. The PA number is found on the paper NOD letter or online through your Trading Partner Account (TPA) under Authorization Status. When entering a PA number on a claim, the authorization number includes “AUTH” plus the numbers that follow.
Please note that QIO prior authorizations will not contain the letters "AUTH" and will not require those letters to be entered.

2.6.6.1. **Eyeglass Lenses and Frames**

**Participants 21 Years and Older**
A participant is eligible for the following.
- This criteria applies to a participant with Medicaid primary, a PA is required. One pair of eyeglasses following recent cataract surgery. The Department follows the Medicare Coverage Determination Guidelines for cataract surgery.
- Prior authorization is required for these criteria if either Medicare or Medicaid is primary. In rare cases such as keratoconus, eyeglasses may prevent further degradation of vision. Requests must contain medical necessity documentation.

2.6.6.2. **Contact Lenses**

**Participants Under 21 Years of Age**
Contact lenses will be covered for extreme myopia or hyperopia requiring a correction equal to, or greater than, minus or plus ten (10.0) diopters in at least one eye, cataract surgery, keratoconus, anisometropia, or other extreme medical conditions precluding the use of eyeglasses as defined by the Department.

**Participants Age 21 and Older**
Contact lenses will be covered only when necessary to treat a chronic condition that affects overall health or that progressively degrades vision (for example, treatment of keratoconus). A letter of medical necessity documenting the need to treat a chronic condition is required for all contact lens prior authorization requests for adults. If the participant has Medicare primary, Classic Optical will bill Medicare for contact lenses.

2.6.6.3. **Keratoconus Diagnosis**
See [www.medunit.dhw.idaho.gov](http://www.medunit.dhw.idaho.gov) or [www.classicoptical.com](http://www.classicoptical.com) for the process specific to ordering fitting kits and specialized custom contact lenses for participants with keratoconus.

2.6.6.4. **Contact Lens Fitting Fees**
When requesting a prior authorization for contact lenses, the contact lens fitting fee should be requested at the same time. Include the CPT codes (92072 and 92310–92317) for contact lens and fitting fee on the request form.

**Exception**: Claims for children or adults in which a fitting of contact lens for treatment of ocular surface disease (contact lens bandage) is needed will be paid by Idaho Medicaid. The CPT code 92071 does not require a prior authorization or KX modifier. Please note the diagnosis code on the claim. The payment for the actual lens is included within the payment for 92071.
### 2.6.6.5. HCPCS Requiring PA

#### Figure 2-1: HCPCS Requiring PA

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<td>Aspheric lenses (V2410, V2430 and V2499)</td>
<td>Plus 8.0 diopter reading or greater.</td>
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<td>Contact Lenses (V2500-V2599)</td>
<td>Under age of 21, with a prescription greater than plus or minus 10.0 diopters, keratoconus, anisometropia, or other extreme conditions. Age 21 and over, to treat a chronic condition such as keratoconus that progressively degrades vision.</td>
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<td>Contact Lens Fitting Fees (92072, 92310 - 92317)</td>
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<td>Eye Exams</td>
<td>Participants under the age of 21 experiencing vision difficulties or symptoms earlier than 365 days.</td>
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<tr>
<td>Frames (V2020)</td>
<td>Participant is 21 and over with Medicaid primary. Participants under the age of 21, frames are included in the authorization if the lens code requires PA.</td>
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<tr>
<td>Frames, Deluxe Specialty (V2025 Miraflex or Erin’s World)</td>
<td>The diagnosis must be documented on the request form for participants under age 21 with special health care needs. If a standard V2020 frame (Cutie, Mainstreet 415, or Kiwi) for a newborn to two year old, submit documentation stating the standard frame was tried and did not fit.</td>
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<tr>
<td>High Index lens material (V2782 or V2783)</td>
<td>V2782 - Minus 4.0 diopter to minus 9.75 diopter prescription in at least one eye. V2783 - Minus 10.0 diopter or higher prescription in at least one eye. Both spherical and cylindrical prescription may be added together for the same eye if both numbers are a minus (-).</td>
</tr>
<tr>
<td>Lenticular Lens Material (V2115, V2121, V2215, V2221)</td>
<td>Equal to or greater than plus or minus 10.0 diopter prescription in at least one eye. Both the spherical and cylindrical prescription may be added together for the same eye if both numbers are a plus (+) or a minus (-).</td>
</tr>
<tr>
<td>Miscellaneous supply code (V2599)</td>
<td>All miscellaneous supply codes require PA. Include the medical necessity and why the least costly supply does not meet the participant’s needs.</td>
</tr>
<tr>
<td>Tints (V2745)</td>
<td>Diagnosis of albinism. Other extreme medical conditions as defined by DHW. Tinted lenses are only payable when medically necessary. Tinted lenses for any other reason including cosmetic or convenience are not covered by Medicaid.</td>
</tr>
</tbody>
</table>

#### 2.7. Non-Covered Services

The following services are not covered by Idaho Medicaid.
- Eye exercise therapy.
- Trifocal lenses.
- Progressive lenses (V2781).
• Tint, Photochromatic (transitions) (V2744).
• Surgery on the cornea for myopic conditions.
• Services/supplies not medically necessary.
• Supplies which are not the least costly item that will reasonably and effectively meet the minimum requirements of the individual's medical needs.

Participants who desire additional features not covered by Medicaid may pay for them separately. The Medicaid contractor will bill the provider separately, and the provider may bill their usual and customary charge to the participant. If the participant cannot adapt to new lenses that were not originally covered by Medicaid, the participant is responsible for any additional charges. In order to bill the participant, the provider must have informed the participant of this policy and the participant agreed to be responsible for payment prior to rendering services not covered by Medicaid.

2.8. **EPSDT Services Available For Participants Under 21**

Services identified as a result of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and which correct or ameliorate a defect will not be subject to the existing amount, scope, and duration limitations, but may require prior authorization. The medical necessity for the additional service must be documented. For example, photochromatic tints may be requested and reviewed under EPSDT on a case-by-case basis.

2.9. **Co-payment**

For information on co-payment, please refer to the section for co-payments in the [General Billing Instructions](#).

2.10. **Post Payment Review**

There are a number of program integrity efforts conducting Medicaid payment review to ensure the integrity of Idaho’s Medicaid program. All providers must grant to the Department and its agents, or the U.S. Department of Health and Human Services and its agents, immediate access to records for review and copying during normal business hours. The Department and its authorized agents may remove from the provider’s premises copies of any records as defined in [IDAPA 16.05.07.101.01](#).

The Department and its authorized agents may request in writing to have copies of records supplied by the provider. The requested copies must be furnished within 20 working days after the date of the written request, unless an extension of time is granted by the Department for good cause. Failure to timely provide requested copies will be a refusal to provide access to records.