

TABLE OF CONTENTS

CHAPTER SEVENTEEN

EYE CARE SERVICES

Rule	Title	Page
560-X-17-.01	Eye Care Services - General	1
560-X-17-.02	Physician Services for Diseases, Injuries, or Congenital Defects	2
560-X-17-.03	Optometrist Services	2
560-X-17-.04	Eyeglasses	3
560-X-17-.05	Billing Procedures	5
560-X-17-.06	Professional Fees	7
560-X-17-.07	Special Situations	7
560-X-17-.08	Assuring High Quality Care	8
560-X-17-.09	Copayment (Cost-Sharing)	8

Chapter 17. Eye Care Services

Rule No. 560-X-17-.01. Eye Care Services - General.

The information contained herein sets forth policies and procedures for providing eye care services under the Alabama Medicaid Program.

(1) Participation. Only in-state and borderline out-of-state providers (within a 30-mile radius of the state line) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The following information must be included in a written enrollment request to Medicaid's Fiscal Agent, Provider Enrollment Division:

1. Name
2. Address
3. Speciality Provider Type
4. Social Security Number
5. Tax Identification Number
6. Medical License Number

(2) Patient Identification

(a) It is most important that a provider's staff verify a Medicaid recipient's eligibility, since claims submitted on ineligible persons cannot be paid by Medicaid. Refer to Chapter 1, General, of this Code, for information about identification of Medicaid recipients.

(3) Prior Authorization

(a) Special exceptions for optometric items, not authorized in this regulation may be made in unusual circumstances when deemed medically necessary by the attending practitioner.

(b) All requests for prior authorization will be submitted in writing to Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624, and must include the following information:

1. Recipient's name.
2. Recipient's Medicaid Number (thirteen (13) digits).
3. Prescription data (complete for both eyes) current.
4. Exception requested.
5. Reason for exception (explain) (Cataract surgery date, etc.).
6. Signature of Practitioner.
7. Address of Practitioner.

(c) A prior authorization number will be assigned by Alabama Medicaid Agency.

(d) The number will be reflected on an approval letter for use in completing the appropriate billing form to the fiscal agent.

(e) A copy of the approval letter from Alabama Medicaid Agency bearing the prior authorization number must be provided to the central Medicaid source if eyeglasses are being obtained from the central source.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982. Amended May 9, 1984. Effective date of amendment January 13, 1988. Effective date of amendment January 13, 1993. Effective date of this Amendment is March 13, 1993.

Rule No. 560-X-17-.02. Physician Services for Diseases, Injuries, or Congenital Defects.

(1) If medically necessary, treatment may include contact lenses (for keratoconus, aphakia, high magnification difference between lenses), when requested in writing and prior authorized by Alabama Medicaid Agency.

(2) Orthoptics (eye exercises) must be prior authorized by Alabama Medicaid Agency. Full information justifying medical necessity (including number of sessions anticipated) must be sent in writing to Medicaid before this service is begun.

(3) Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied under this paragraph when needed because of visual changes due to eye disease, surgery, or injury.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982. Effective date of this amendment is March 13, 1993.

Rule No. 560-X-17-.03. Optometrist Services.

(1) Services That May be Provided Other Than Correction of Refractive Error.

(a) In the conduct of an optometric eye examination, if the Optometrist suspects or detects abnormalities or irregularities requiring medical treatment the case will be referred to an appropriate doctor of medicine or osteopathy.

(b) If medically necessary, contact lenses (for Keratoconus, aphakia, high magnification difference between lenses), may be provided when prior authorized by Medicaid.

(c) Orthoptics (eye exercises) must be prior authorized by Alabama Medicaid Agency. Full information justifying medical necessity (including number of sessions anticipated) must be sent in writing to Medicaid before this service is begun.

(d) Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied under this paragraph when needed because of visual changes due to eye disease, surgery, or injury.

(e) Photochromic lenses and UV400 coating may be prior authorized when justified in writing.

(f) Post-operative cataract patients may be referred, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Any subsequent abnormal or unusual conditions diagnosed during follow-up care shall be referred back to the ophthalmologist. When submitting claims the appropriate modifier identifying post-operative management must be utilized. Anytime the surgeon receives payment for the global amount the post-op claim will deny. No post-operative management claim will be

processed until referring ophthalmologist has received payment for surgery. It shall be the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.

(2) Examination for Refractive Error Only.

(a) A complete eye examination and work-up is expected and will include the following: case history, eye health examination, visual acuity testing, visual fields (if indicated), tonometry, prescribing eyeglasses (if indicated), and determining optical characteristics of lenses (refraction).

(b) For children, eye tension and visual fields should be done only if indicated.

(c) Medicaid recipients twenty-one (21) years of age and older are authorized one (1) complete eye examination and work-up each two (2) calendar years; recipients under twenty-one (21) years of age are authorized the same service each calendar year or more often if medically necessary (documented).

(d) Diagnosis will be indicated as refractive error findings.

(e) Services rendered to Medicaid recipients while confined to bed in a health care facility may be rendered as long as it is documented by the patient's assigned physician that the patient is unable to leave the facility and the examination is medically necessary.

(3) If eyeglasses are required and provided, services will include verification of prescription, dispensing of eyeglasses (including laboratory selection), frame selection, procurement of eyeglasses, and fitting and adjusting of eyeglasses to the patient.

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 435.520(3), 441.30(a)(b); State Plan, Attachment 3.1-A, page 2.2, and page 5.1. Rule effective October 1, 1982. Amended June 8, 1985. Effective date of emergency rule is December 1, 1986. Amended March 12, 1987. Emergency Rule Effective Date April 15, 1993. Amended May 13, 1993. Effective date of this amendment August 12, 1994.

Rule No. 560-X-17-.04. Eyeglasses.

(1) Authorization

(a) Recipients twenty-one (21) years of age and older are authorized one (1) pair of eyeglasses each two (2) calendar years if indicated by an examination; recipients under twenty-one (21) years of age are authorized the same service each calendar year or more often if medically necessary (documented). These limitations also apply to fittings and adjustments.

(b) Additional eyeglasses, which are medically necessary, may be prior authorized by Alabama Medicaid Agency (Medicaid) for treatment of eye injury, disease or significant prescription change.

(c) The provider should forward a letter to Medicaid justifying medical necessity prior to ordering the eyeglasses (reference Rule No. 560-X-17-.01,(3).

(d) A response of either approval or denial will be returned to the provider. If approved, a six digit prior authorization number will be assigned (reference Rule No. 560-X-17-.01, (3), (c) and (d).

(e) If a patient desires eyeglasses other than those provided by Medicaid he/she must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for retention with the patient's records: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

(2) Procurement.

At the option of the provider making the frame measurements, eyeglasses in conformance with Alabama Medicaid standards, may be procured from either the central Medicaid source or from any other source. Medicaid will pay no more than the contract price charged by the central source.

(3) Standards and Price of Frames.

(a) A list of authorized frames and contract prices will be sent to each provider by Alabama Medicaid Agency.

(b) The authorized frames, or frames of equal quality, will be provided for Medicaid recipients at the contract prices shown on the list. (Under normal circumstances the date of service for eyeglasses will be the same as the date of examination.)

(c) Patients having old frames, which are suitable and acceptable under the standards contained herein, may have new lenses installed in lieu of being issued new eyeglasses. Medicaid will pay for the lenses only. The following statement should appear on the claim form that is submitted for the lenses: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

(d) Services provided under this sub-paragraph are subject to the program benefit limitations.

(4) Lenses.

(a) Lens specifications are authorized at the specified contract price.

(b) Lenses will be of clear glass or clear plastic, unless prior authorized by Alabama Medicaid Agency because of unusual conditions, as indicated in Rule 560-X-17-.03(11). All lenses will meet FDS impact-resistant regulations.

(c) Spherical lenses must be at least a plus or minus .50 diopters; the minimum initial correction for astigmatism only (no other error) is .50 diopters.

(d) Prior authorization is to be obtained by writing Alabama Medicaid Agency.

(5) Frames.

(a) Patients with old lenses which are suitable and acceptable under the standards contained herein, may have them installed in a new frame in lieu of being issued new eyeglasses. Medicaid will pay for the frame only. The following statement

should appear on the claim form that is submitted for the frame: "I hereby certify that I used this patient's old lenses and that I did not accept any remuneration therefore."

(b) Services provided under this sub-paragraph are subject to the program benefit limitations.

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 435.520(3), Section 441.30(a)(b); State Plan, Attachment 3.1-A, page 2.2 and 5.1. Rule effective October 1, 1982. Amended June 8, 1985. Effective date of emergency rule is December 1, 1986. Amended March 12, 1987. Effective date of this amendment January 13, 1988. Effective date of this amendment is March 13, 1993.

Rule No. 560-X-17-.05. Billing Procedures.

(1) All claims for payment of services rendered, filed by Ophthalmologists, Optometrists, and Opticians are to be filed on appropriate form provided by the fiscal agent.

(2) Claims are to be forwarded directly to the Medicaid fiscal agent for payment within one year of the date of service. The Medicaid Provider Manual contains information on claims processing.

(3) A claim for payment may be submitted for a cancelled order.

(4) Eye Examination Only.

(a) The claim should specify "Complete Eye Examinations and Refraction."

(b) If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code. This claim should be sent directly to the Medicaid fiscal agent.

(5) Medical Condition and Treatment.

The claim should be sent directly to the Medicaid fiscal agent.

(6) Eye Examination (Including Refraction) and Fitting (Including Frame Service, Verification, and Subsequent Service) all by the same provider when eyeglasses are procured from the central Medicaid source contractor:

(a) Claims are to be sent directly to the Medicaid fiscal agent.

(b) The claim will separately identify the extent of the examination, refraction and fitting. Lenses and frames are not to be billed by the practitioner.

(c) The Medicaid job order form reflecting all necessary prescription data including frame required will be forwarded to Central Medicaid Source Contractor to fill the prescription, and return the eyeglasses to the examiner for delivery to the patient. Patient or Authorized Signature box will contain appropriate signature, or the statement "Signature on file."

(d) The Central Medicaid Source Contractor will submit claims for payment to the fiscal agent.

(7) When eyeglasses are NOT procured from the Central Medicaid Source Contractor.

(a) The claim should separately specify the extent of the examination performed refraction, fitting, lenses, and frame.

(b) When Opticians provide eyeglasses the claim should only identify the fitting service, lenses and frame.

(c) The claim is sent directly to the fiscal agent. Reimbursement for lenses and frames will be at the central source contract prices.

(8) Fitting (Including Frame Service, Verification, and Subsequent Service) only, when eyeglasses are procured from the Central Medicaid Source Contractor:

(a) The claims are to be sent for payment directly to the Medicaid fiscal agent.

(b) The claim will specify the fitting services only.

(9) Additional billing instructions will be published as the need arises by the Medicaid fiscal agent.

(10) An Alabama Medicaid provider may bill an Alabama Medicaid recipient when the recipient has exhausted all of his/her allowed Medicaid benefits for the calendar year, or when the service rendered by the provider is a non-covered benefit as outlined in the Alabama Medicaid Agency Administrative Code.

(a) Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are prohibited.

(11) Ophthalmologists and optometrists are required to collect and it is the Medicaid recipient's responsibility to pay the maximum designated copayment amount for each service rendered. This includes patients with Medicare.

(a) A provider agrees to accept as payment in full the amount paid by the State, plus any cost-sharing amount to be paid by the recipient, for covered items, and further agrees to make no additional charge(s) for covered items to the recipient, sponsor, or family of the recipient, except the appropriate allowable copayment amount.

Authority: State Plan, Attachment 4.18-A; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; Section 447.15. Rule effective October 1, 1982. Amended July 9, 1984. Effective date of amendment June 8, 1985. Effective date of this Amendment is March 13, 1993.

Rule No. 560-X-17-.06. Professional Fees.

All eye care service providers shall be paid their usual and customary fees in accordance with Federal regulations for all services rendered, including examinations and the prescribing, procuring, and fitting and adjusting of eyeglasses, not to exceed the 75th percentile of the range of fees prevailing in the statewide profile.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.
Rule effective October 1, 1982.

Rule No. 560-X-17-.07. Special Situations.

(1) Eye Care for Patients Eligible for Both Medicare and Medicaid.

See the Medicaid Provider Manual for instructions in filing claims when the Medicaid patient is entitled to benefits covered by Medicare.

(2) If eyeglasses are prescribed under conditions not covered by Medicare, instructions and procedures appearing in other paragraphs of this chapter should be followed.

(3) Unusual Situations.

(a) Services for unusual situations may be provided when prior authorized. Full, written information justifying medical necessity must be sent to Medicaid prior to the service being rendered.

(b) Please refer to Rule No. 560-X-17-.01, (3) of this chapter for prior authorization procedures.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 401, Et seq.
Rule effective October 1, 1982. Effective date of this amendment January 13, 1988.

Rule No. 560-X-17.08. Assuring High Quality Care.

(1) Under the provisions of Federal and State law, Medicaid must establish a mechanism to insure that all such care is of good quality and that the service(s) for which billing was made, conforms to that which was done. See Chapter 2, Rule 560-X-2-.01 (2) (f) and (3), for criteria.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 401, Et seq.
Rule effective October 1, 1982.

Rule No. 560-X-17-.09. Copayment (Cost-Sharing).

(1) Ophthalmologists and optometrists are required to collect and it is the Medicaid recipient's responsibility to pay the maximum designated copayment amount for each service rendered.

(2) The copayment amount does not apply to services provided for the following:

- (a) Recipients under 18 years of age
- (b) Emergencies
- (c) Pregnancy
- (d) Nursing home residents

(3) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Authority: State Plan, Attachment 4.18-A; 42 C.F.R. Section 447.15, 447.50, 447.55.
Rule effective June 8, 1985.