COVERED SERVICES

Medicaid may reimburse for the visual services described in this chapter. The services must be medically necessary and provided to eligible Medicaid beneficiaries (see Section 46.2 for Beneficiary Requirements).

Only those services designated in the Louisiana Medicaid Vision (Eyewear) Fee Schedule can be reimbursed by Medicaid to an optometrist, ophthalmologist, and optician.

NOTE: Some eyewear services and materials require prior authorization (PA) before rendering. The Vision (Eyewear) Fee Schedule on www.lamedicaid.com indicates which services require PA.

Eye Exams

Medicaid covered eye exams are available to Medicaid eligible beneficiaries who are under 21 years of age and are limited to one per calendar year. (Refer to *Chapter 5 Professional Services* for more information).

Lenses

Lenses must be of good quality and un-tinted, conforming to the Z 80.1 hardened glass or plastic lens standards of the American National Standards Institute, Federal Food and Drug Administration regulations, and federal law.

In order to receive Medicaid reimbursement for single vision lenses, at least one lens must exceed +1.00 sphere, -0.50 sphere, or +/-0.50 plano cylinder. Only spheres or compounds +/- cyl series, properly transposed to find price brackets, should be prescribed.

If a complete pair of eyeglasses (frames and lenses) is delivered to a Medicaid beneficiary on the same date of service, the provider must bill for all components of the eyeglasses. Providers may not bill Medicaid for lenses only and let the patient pay for the frames. Providers may dispense replacement lenses to a complete pair of eyeglasses that a beneficiary already owns.

Bifocal/trifocal lenses will only be considered when medically necessary. Bifocal/trifocal lenses requested for convenience will not be authorized.

Polycarbonate lens - add-on, per lens (S0580) will only be considered when medically necessary, i.e. for a child who has seizures and may be prone to fall, a child who is blind in one eye, etc.

NOTE: If a Medicaid beneficiary for whom polycarbonate lenses are not medically necessary chooses to pay the eyewear provider out-to-pocket for an "upgrade" from CR-39 to polycarbonate, they may be permitted to do so. The provider shall have the beneficiary or legal guardian sign an agreement stating that payment is an un-coerced choice for the upgrade and that they understand and assumes the responsibility for payment for the services.

Frames

Medicaid beneficiaries must be offered a choice between metal or plastic frames. The frames must be sturdy and nonflammable. Both the metal and non-metal frames must carry at least a one-year manufacturer's warranty.

Providers may dispense a replacement frame to a complete pair of eyeglasses, which a beneficiary already owns. Replacement frames should not be billed to Medicaid if the frame is covered by the one-year manufacturer's warranty.

If eyeglasses are damaged, the first line of coverage shall be to utilize the manufacturer's warranty. If the frames are outside of the manufacturer's warranty, the provider must pursue the most cost-effective method to repair the damaged glasses. If repair or replacement of the damaged parts is not feasible, the full replacement of eyeglasses will be covered. Documentation that the repair or replacement of the damaged parts is not feasible must be obtained before the full replacement of eyeglasses.

If a complete pair of eyeglasses (frames and lenses) is delivered to a Medicaid beneficiary on the same date of service, the provider must bill for all the components of the eyeglasses. Providers may not bill Medicaid for frames only and let the patient pay for the lenses.

Deluxe frames require prior authorization and will only be considered when medically necessary, i.e. child has a wide nose bridge due to a medical syndrome, or child has a small head and regular frames would not fit, etc.

Contact Lenses

Medicaid reimburses for rigid or soft contact lenses. Medicaid may reimburse for continuous wear lenses when the beneficiary cannot wear normal soft lenses. All contact lenses require prior authorization by Medicaid. It must be clearly stated and written on the prior authorization request form whether it is a new fitting or replacement lenses.

Contact lenses will only be considered when medically necessary and no other means can restore vision. Medicaid does not reimburse for contact lenses for cosmetic purposes.

Contact lenses may be covered when the beneficiary has one of the following conditions:

1. An unusual eye disease or disorder exists which is not correctable with eyeglasses;

2. Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear;

3. Irregular cornea or irregular astigmatism (does not apply if the beneficiary has had previous refractive surgery);

4. Significant, symptomatic anisometropia; and

5. Aphakia (post-surgical).

In order for the provider to be reimbursed by Medicaid for contact lenses, the provider must obtain prior authorization from Medicaid (refer to Section 46.4 for required documentation for prior authorization requests). The prior authorization request is then reviewed to determine if the beneficiary is being fitted with the proper type of lenses. If either soft or rigid lenses could be used, Medicaid will approve the least expensive type.

Reimbursement for "Fitting of Spectacles"

Medicaid provides separate reimbursement for the "fitting of spectacles" on the same day or subsequent day as an optometrist or ophthalmologist office visit. The most appropriate and inclusive Current Procedural Terminology (CPT) code shall be used for the "fitting of spectacles." These relevant codes are located on the Professional Services fee schedule.

Reimbursement covers delivery and final adjustment to the visual axis and anatomical topography of Medicaid covered eyewear. If final adjustments to the visual axes and anatomical topography are **NOT** performed during the beneficiary's return, the provider must **NOT** bill for the "fitting of spectacles." For example, if the beneficiary returns to the office only to pick up eyewear, billing of the procedure code for fitting of spectacles is considered inappropriate billing.

Eyewear Replacement Policy

Eyewear is limited to three (3) pairs per calendar year without review. Billing for the fourth and subsequent pairs must have documentation attached justifying the need for more than three (3) pairs of eyewear per year.

Acceptable documentation includes, but is not limited to, the following:

1. Documentation that shows the necessity of changing the prescription for the eyewear more than three times in the calendar year; or

2. Copies of the different prescriptions for eyeglasses, which were written within the calendar year.

For services that do not require prior authorization, providers should fill the prescription, i.e., order the glasses from the manufacturer and dispense the glasses to the beneficiary, prior to filing for payment. Providers should not hold the eyewear until payment is received.

Date of delivery of eyewear is the date of service on the claim form.

Providers may not require a payment/deposit for eyewear pending payment from Medicaid. Payment from the Louisiana Medicaid Program must be for medically necessary services and must be accepted as payment in full.

Eyewear may not be upgraded for cosmetic purposes under any circumstances.

Medicaid covers medically necessary eyewear. Medicaid does not cover any eyewear, initial or replacement that is to be used as “spare” or “back-up” eyewear. The beneficiary may choose to purchase (out of pocket) duplicate eyewear that is to be used as “spare or “back-up” eyewear.