COVERED SERVICES

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

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

NOTE: Some eye wear services and materials require prior authorization (PA) before rendering. The Eye Wear Fee Schedule (Appendix A) indicates which services require PA.

Eye Exams

Medicaid covered eye exams are available to Medicaid eligible recipients 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 recipient 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 eyeglass in which a recipient 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 recipient for whom polycarbonate lenses are not medically necessary chooses to pay the eye wear provider out-to-pocket for an "upgrade" from CR-39 to

polycarbonate, he/she may be permitted to do so. The provider shall have the recipient or legal guardian sign an agreement stating payment is an un-coerced choice for the upgrade and that he/she understands and assumes the responsibility for payment for the services.

Frames

Medicaid recipients 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 recipient 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 of when 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 recipient 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 recipient 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 if 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 recipient has one of the following conditions:

- An unusual eye disease or disorder exists which is not correctable with eyeglasses;
- Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear;
- Irregular cornea or irregular astigmatism (does not apply if the recipient has had previous refractive surgery);
- Significant, symptomatic anisometropia; and
- 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 recipient 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.

Same-Day or Subsequent Day Follow-Up Office Visit Policy

A separate same-day or subsequent day follow-up optometrist or ophthalmologist office visit is allowed for the purpose of the delivery, and final adjustment to the visual axis and anatomical topography of Medicaid-covered eye wear. Presence of the physician is not required. If the visit meets these criteria, procedure code 99211 should be used when billing for this service. Documentation in the patient's record should reflect that the patient returned for a separate visit on the same day or subsequent day for the purpose of the delivery and final adjustment of the eye wear, and must include a description of the services provided. If the patient returns on the same day or subsequent day simply to pick up their eye wear, and no final adjustments to the visual axes and anatomical topography are performed, the provider must not bill for this service.

Eye Wear Replacement Policy

Eye wear is limited to three pair per calendar year without review. Billing for the fourth and subsequent pairs must have documentation attached justifying the need for more than three pair of eye wear per year.

Acceptable documentation includes, but is not limited to:

- Documentation which shows the necessity of changing the prescription for the eye wear more than three times in the calendar year; or

- 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 recipient prior to filing for payment. Providers should not hold the eye wear until payment is received.

Date of delivery of eye wear is the date of service on the claim form.

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

Eye wear may not be upgraded for cosmetic purposes under any circumstances.

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