Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Vision Care Services

Division of Integrated Healthcare

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1 General information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as Section I: General Information and the Physician Services manual.

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

1-1 General policy

For adult members, vision services include one annual examination and, when medically necessary, treatment of visual deficiency or removal of a foreign body.

Eyeglasses, including lenses and frames or other corrective lenses are covered for pregnant women and EPSDT eligible members. These are not covered for non-pregnant adults (age 21 and older).

1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee for service Medicaid members.

A Medicaid member enrolled in a Managed Care Plan (MCP) (health, behavioral health or dental plan) must receive services through that plan with some exceptions called “carve-out services,” which may be billed directly to Medicaid. An MCP may use this manual as a reference to find out what Medicaid covers.

Refer to the provider manual, Section I: General Information, for information regarding MCPs and how to verify if a Medicaid member is enrolled in an MCP. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee for service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid member services hotline at (844) 238-3091 for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. Therefore, if a Medicaid member is enrolled in an MCP, a fee for service claim will not be paid unless the claim is for a carve-out service.

Eligibility and plan enrollment information for each member is available to providers using the Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility.

1-3 Definitions

Additional definitions of terms used in Medicaid programs are available in Section I: General Information. Definitions specific to the content of this manual are provided below.

Eyeglasses

Means lenses, including frames, contact lenses, and other aids to vision that are prescribed by a physician skilled in diseases of the eye or by an optometrist.

Ophthalmologist

A person specifically trained as a physician who specializes in anatomy, physiology, pathology, disorders and treatment of the eye. Ophthalmologists must be licensed to practice medicine in the state where the services are provided.

Optician

A person specifically trained to translate optical prescriptions, prepare lenses, and fit and dispense eyeglasses. Opticians are reimbursed as 'optical suppliers' who must be licensed by the appropriate governmental authority licensing businesses in the state where the services are provided.

Optometrist

A person specifically trained and licensed, in accordance with the Utah Optometry Practice Act and the State of Utah Administrative Rule, Optometry Practice Act Rule (r156-16a). Optometrists must be licensed in the state where the services are provided.

2 Provider participation requirements

2-1 Provider enrollment

Providers must be enrolled as a Utah Medicaid provider to be reimbursed for services. Refer to provider manual, Section I: General Information for provider enrollment information.

3 Member eligibility

A Medicaid member is required to present the Medicaid member card before each service, and every provider must verify each member's eligibility each time before services are rendered. For more information regarding verifying eligibility, refer to provider manual, Section I: General Information, Verifying Medicaid eligibility, and to the Eligibility Lookup Tool located at https://medicaid.utah.gov/eligibility.

4 Program coverage

Procedure codes

With some exceptions, procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

4-1 Covered services

4-1.1 Eye examination

The eye examination includes evaluation, diagnosis and treatment of visual deficiency and abnormalities of the eye and visual system. Examinations must be documented as medically necessary in the member record.

The examination fee includes the refraction (glasses prescription) and the office visit. Do not bill an office visit separately from the eye examination (See Chapter 6, Billing).

One routine eye examination per year is covered for Medicaid members with two exceptions.

1. An eye examination may be completed whenever there is a medical need. The Medicaid member must have symptomatic eye problems prior to the examination for which treatment is medically necessary and documented. Examining or screening members to determine if they have an eye problem is not covered. This specifically includes nursing homes and ICF's/ID annual visual screening services.
2. If necessary, an eye examination may be done when glasses are lost or broken (See Chapter 4-1.4, Repairs).

4-1.2 Corrective lenses

Medical necessity is required for corrective lens coverage. Medical necessity includes a change in prescription or replacement due to normal lens wear. Corrective lenses must be suitable for indoor or outdoor, day or night use.

Lenses covered include single vision, bifocal, trifocal, with or without slab-off prism, in clear glass or plastic. If the prescription changes, the same frame must be used if possible (See Chapter 4-1.3, Frames).

Separate charges for glasses fitting are not reimbursable. Fitting fees are included in the reimbursement rate for the provided items.

4-1.3 Frames

When medically necessary, Medicaid provides one standard frame, plastic or metal. Frames must be reusable and if the lens prescription changes, the same frame must be used when possible. Medicaid reimburses one pair of eyeglasses every 12-month period.

4-1.4 Repairs

Medicaid will reimburse for repair or replacement of a damaged lens or frame.

4-1.5 Eyeglasses replacement

Replacement eyeglasses are allowed for eligible members once every 12-month period. Prior authorization is required to replace frames sooner than 12 months; replacement lenses are covered and do not require prior authorization. If the lenses alone need replacing, the provider must use existing frames.

Prior authorization may be issued for a new pair of eyeglasses, even though 12 months have not passed since a member's last pair was dispensed when one or more of the following reasons for medical necessity are met:

1. There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye.
2. A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary.
3. A change in the member's head size warrants a new pair of eyeglasses.
4. The member has had an allergic reaction to the previous pair of eyeglasses.
5. The original pair is lost, broken, or irreparably damaged; the dispensing provider must obtain a written statement explaining this from the member (or the member's caretaker) with the prior authorization request.

4-1.6 Contact lenses

Contact lenses require written prior authorization. Refer to 6-1, Prior authorization.

1. Contact lenses may be covered under the following circumstances:
    a) Visual acuity cannot be corrected to 20/70 in the better eye with glasses lenses.
    b) The refractive error is greater than +- 8D.
    c) An unusual eye disease or disorder exists which is not correctable with eyeglasses.

d) To correct aphakia, keratoconus, nystagmus, or severe corneal distortion.
e) Other special medical conditions which medically require a contact lens.

2. Fitting contact lenses includes determining correction measurements, writing the prescription, fitting and follow-up care necessary for proper wear of the contact lens. Medicaid will not reimburse any additional office visits for any of these services.
3. Soft contact lenses may be approved when medically necessary because of a condition described in "A" above and for either circumstance below:
    a) Prescribed by an ophthalmologist or optometrist as a "bandage" to treat eye disease or injury.
    b) Prescribed for a member who is unable to wear hard contacts due to the shape or surface of the eye and who is unable to obtain the necessary correction with glasses.
4. Gas permeable contact lenses may be approved when a specific medical need exists which precludes the use of glasses.
5. Contact lenses are not covered for moderate visual improvement and/or cosmetic purposes.

4-1.7 Medication

Medications may be prescribed to treat eye disease or injury. The treating optometrist must be certified under the Optometry Practice Act. Medications dispensed in an office are not reimbursable, they are part of the office visit.

4-1.8 Low vision aids

Low vision aids or materials may be covered. These items require prior authorization and manual pricing. See Chapter 6-1, Prior authorization.

4-1.9 Prostheses

Prostheses, such as an artificial eye, and associated services are covered when medically necessary.

4-1.10 Member chooses non-covered services or upgrades

With few exceptions, a provider may not bill a Medicaid member, as the Medicaid payment is considered payment in full. Exceptions may include a member request for service that is not medically necessary and therefore not covered. Examples of services considered not medically necessary: more expensive frames, tinted lenses, lenses of special design.

For a provider to bill the member the following conditions must be met. (See also Section I: General Information, Exceptions to prohibition on billing members).

1. The provider has an established policy for billing all Medicaid members for services not covered by a third party. (The charge cannot be billed only to Medicaid members).
2. The member is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
3. The member agrees to be personally responsible for the payment.
4. The agreement is made in writing between the provider and the member which details the service and the amount to be paid by the member.

Unless all four conditions are met, the provider may not bill the member for the non-covered service. Further, the provider may not “hold” the member's Medicaid card as guarantee of payment, nor may any other restrictions be placed upon the member.

If providing upgraded services such as more expensive frames, tinted lenses, or lenses of special design, bill the covered code and charges on the first line. On the second line, bill the non-covered code, including the modifier “GX” (HCPCS “GX” modifier description: Notice of liability issued, voluntary under payer policy) and the charges on the second line. This indicates that the member has signed a memo of understanding of the payment responsibility for the upgrade(s). The code with the GX modifier will be non-payable. The memo of understanding must be kept in the provider’s medical record for the member.

The amount paid by the member is calculated by taking the difference between the usual and customary charge for the more expensive item and the usual and customary charge for the covered item. For example, if the usual and customary charge for the basic frame were $35 and the member wanted frames that were presently advertised for $50, the member would be responsible to pay an additional $15. Remember, because Medicaid pays $27.61 for the $35 basic frame, the provider accepts this as payment in full and cannot bill the member for the $7.39 difference.

5 Non-covered services and limitations

For additional non-covered services or limitations, refer to the Coverage and Reimbursement Lookup Tool at the Medicaid website at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

5-1 Non-covered services

The following services are NOT covered by Medicaid.

1. Additional glasses, such as reading glasses, safety glasses, distance glasses, or “spare glasses”
2. Extended wear contact lenses
3. Contact lenses for moderate visual improvement and/or cosmetic purposes
4. Sunglasses, tints, or any other mechanism such as light-sensitive lenses that “darken” or photo grey lenses
5. Oversized, exclusive, or specially designed lenses
6. Special cataract lenses, unless medically necessary. Only clinical cataract lenses are covered.
7. No-line bifocal lenses and no-line trifocal lenses
8. Replacement of glasses that are broken or lost due to abuse and neglect of the member (See Chapter 4-1.6, Eyeglasses replacement for more information).
9. Repairs due to member neglect or abuse
10. Medications dispensed in an office

11. Screening examination to determine if member has an eye problem
12. Corneal Topography
    a) With a non-covered service (e.g., radial keratomy, lasix eye surgery)
    b) As a screening examination
    c) Separate from evaluation & management ophthalmological services (i.e., 92002-92014)
    d) Optical Coherence Tomography (OCT) (An ultrasonic method to evaluate ocular structures which is considered investigational)
13. Biometry by ultrasound 76516 and 76519 are subject to correct coding initiative edits.
    a) If both studies (76511 or 76516 and 76519) are reported, the charges are combined and processed under code 76519. The global service for code 76519 includes a bilateral technical component and unilateral professional component. When the procedure is completed on the second eye, only the professional component should be billed.
    b) It is not considered medically reasonable or necessary to perform both an A-scan and optical coherence biometry (OCB). If biometry by partial coherence interferometry (92136) and an A-scan (76516, 76519) is completed, a mutually exclusive edit will post. The A-scan procedure (76516 or 76519) will be paid, and the code 92136 will be denied.

6 Billing

Vision care services may be billed electronically or on paper, using the CMS-1500 (08/05) claim format. Refer to the provider manual, Section I: General Information, for detailed billing instructions.

If a member chooses non-covered services or upgrades, refer to 4-1.11 Member chooses non-covered services or upgrades for billing information.

6-1 Prior authorization

Prior authorization may be required for certain services. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if

prior authorization is necessary and obtain authorization before providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

Prior authorization (PA) information is provided in the provider manual, Section I: General Information. Code specific coverage and prior authorization requirements are provided on the Medicaid website, Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

When requesting prior authorization, complete the requirements found in Section I: General Information include documentation supporting the diagnosis.
Examples of information to include in the prior authorization request.

1. Results of refraction in each eye.
2. Statement concerning presence of aphakia, keratoconus, or nystagmus.
3. If the diagnosis is corneal distortion include test results.
4. If post cataract removal, date of surgery.
5. If soft or gas permeable lenses are being requested, evidence of a physical problem precluding the use of hard contacts.

7 References

1. Utah Code 26-18-3
2. Utah Optometry Practice Act, Title 58, Chapter 16a
3. 42 CFR 441.30, Optometric services
4. 42 CFR 440.120 (d), Prescribed drugs, dentures, prosthetic devices, and eyeglasses