Optometrist and Optician Services

Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

All optometrists licensed to practice in the state of Iowa or licensed to practice in other states are eligible to participate in Medicaid.

All opticians in Iowa or in other states are eligible to participate in Medicaid. **NOTE:** Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

B. COVERAGE OF SERVICES

Payment will be approved for medically necessary services and supplies provided by an optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limits and exclusions. Covered optometric services include a professional component and materials.

Payment will be approved only for certain services and supplies provided by opticians. Payment will be made for services only when prescribed by a physician (M.D. or D.O.) or an optometrist (O.D.).

Eye examinations, medical services, and auxiliary procedures listed below are not covered for opticians. Lens and frame services are covered for both optometrists and opticians.

1. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for your agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing provider
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code (IAC) Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

2. Materials

Ophthalmic materials that are provided according to the prescription provided by a physician or an optometrist shall meet the following standards:

- Corrected curve lenses, unless clinically contraindicated
- Standard plastic, plastic and metal combination, or metal frames
- Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance

High power lenses with a correction of plus or minus six diopters should be billed using the appropriate "V" code.

High index lenses should be billed using V2782 or V2783 in addition to the base code for the correction.

Rose tints I and II are to be covered in the cost of the lenses. Glasses with other cosmetic tints are not covered.

3. Optometrist Services Covered

a. Auxiliary Procedures

Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis. The following auxiliary procedures and special tests are payable when performed by an optometrist.

- Serial tonometry. Single tonometry is part of the intermediate and comprehensive examinations and is not payable as a separate procedure. Serial tonometry is a payable benefit.
- Gonioscopy
- Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examinations and, if performed in conjunction with that level of service, is not payable as a separate service procedure.
- Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.
- External photography
- Fundus photography
- Retinal integrity evaluation when performed with a three minor lens

b. Eye Examinations

The coverage of eye examinations depends on the purpose of the examination. Routine eye examinations are covered once in a 12-month period. Use the diagnosis code V72.0 and the applicable CPT procedure code when billing a routine eye examination.

Nonroutine eye exams are covered when the examination is the result of a complaint or symptom of an eye disease or injury. Use the applicable diagnosis code when billing nonroutine eye examinations.

The following levels of service are recognized for optometric examinations:

- Intermediate examination: A level of optometric or ophthalmological service pertaining to medical examination and evaluation with initiation or continuation of a diagnostic and treatment program.
- Comprehensive examination: A level of optometric or ophthalmological service pertaining to medical examination and evaluation with initiation or continuation of a diagnostic and treatment program and a general evaluation of the complete visual system.

c. Medical Services

Payment will be approved for medically necessary services and supplies within the scope of practice of an optometrist. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

4. Optometrist and Optician Services

The following services are covered when provided by either an optometrist or an optician.

a. Contact Lenses

Preparation and fitting of contact lenses are covered when:

- Required following cataract surgery, for documented keratoconus, documented aphakia, high myopia, anisometropia, trauma, severe ocular disease, irregular astigmatism, or for treatment of acute or chronic eye disease, or
- Vision cannot be corrected with glasses.

Prior authorization is not required in these situations. Procedure codes 92310 – 92317 are not payable to optician providers. Soft contact lenses and replacements are allowed when medically necessary.

Gas permeable contact lenses are limited as follows:

- Up to 16 lenses for children up to 1 year of age.
- Up to 8 lenses every 12 months for children 1 through 3 years of age.
- Up to 6 lenses every 12 months for children 4 through 7 years of age.
- Two lenses every 24 months for members 8 years of age and over.

b. Fitting and Dispensing Fee

Reimbursement for fitting and dispensing of eyeglass lenses and frames is included in the fee for the lenses and frames.

c. Frame Services

Frame services are payable only when lenses are provided. See Prior Authorization.

- Selection and styling
- Sizing and measurements
- Fitting and adjustment
- Readjustment and servicing

New frames are limited as follows:

- Up to 3 times for children up to 1 year of age
- Up to 4 times per year for children 1 through 3 years of age
- One frame every 12 months for children 4 through 7 years of age
- Once every 24 months after 8 years of age
- When there is a covered lens change and the new lenses cannot be accommodated in the current frame

Safety frames are allowed for:

- Children through 7 years of age
- Members with a diagnosis related disability or illness where regular frames would pose a safety risk

Deluxe (wrap-around) frames are covered for children up to two years of age.

d. Prosthetic Eye

Payment will be made for preparation and fitting of a prosthetic eye when provided by an optometrist or optician.

e. Repairs and Replacement of Frames, Lenses, or Components

Repairs and replacement of frames, lenses, or component parts are covered. Frame front, temples, pads, top of rim, soldering, etc. are covered. **EXCEPTION:** When parts or repairs provided as a courtesy to other customers are provided to Medicaid members, charges cannot be billed to Medicaid.

Consider the repair of existing frames before dispensing new frames when:

- It is evident that the repair of existing frames is less costly than providing a new frame, and
- Such repairs would again provide a serviceable frame for the use of the member.

A service charge for installing the frame front, temples, pads, top of rim, soldering, etc., may be approved in addition to the materials, providing no other professional service charge or dispensing fee is made. The service fee shall not exceed the dispensing fee for a replacement frame.

f. Replacement of Glasses

Payment will be approved for replacement of glasses when the original glasses have been lost or damaged beyond repair. When lenses are replaced due to loss or damage, the most current lens correction prescription should be used.

Replacement of lost or damaged glasses for adults age 21 and over is limited to once every 12 months, except when the member has a mental or physical disability, such as a seizure disorder or mobility problems.

Replacement of lost or damaged glasses for children under 21 years of age is not limited. When glasses are repeatedly lost or damaged, the provider should counsel the parent and child (if age appropriate) regarding proper care and safekeeping of eyeglasses.

When a lens or the frame is damaged beyond repair, only the damaged materials shall be replaced. Consider the repair of existing frames before dispensing new frames when:

- It is evident that the repair of existing frames is less costly than providing a new frame, and
- Such repairs would again provide a serviceable frame for the use of the member.

When the original glasses have been lost or damaged beyond repair, you must show the modifier “RA” on the claim form directly after the “V” procedure code for replacement lenses and frames. Failure to use this modifier will result in denial of the claim if the member had previously received glasses in the last two years. Documentation of whether the eyeglasses have been lost or damaged beyond repair must be included in the provider records.

When the member is over 21 and has a mental or physical disability that contributes to the loss or breakage of eyeglasses, the “KX” modifier, as well as the “RA” modifier must be used. Documentation of the disability must be included in the provider records.

g. Single Vision and Multifocal Lens Service

When lenses are necessary, the following professional and technical optometric services shall be provided:

- Ordering of corrective lenses
- Verification of lenses after fabrication
- Adjustment and alignment of completed lens orders

When there is a lens correction, new lenses are limited as follows:

- Up to 3 times for children up to 1 year of age
- Up to 4 times per year for children 1 through 3 years of age
- Once every 12 months for children 4 through 7 years of age
- Once every 24 months after 8 years of age

Protective lenses (polycarbonate or equivalent material) are allowed for:

- Children through 7 years of age
- Members with adequate vision in only one eye
- Members with a diagnosis related illness or disability where regular lenses would pose a safety risk

Prisms are covered as follows:

- Slab off prism (V2710) when necessary to adequately correct vision
- Other prisms (V2715) when vision cannot adequately be corrected with slab off prisms
- Press on prisms (V2718) when prior authorization has been obtained

5. Place of Service

Payment is made for services provided to the member in the optometrist's office or clinic, the member's home, nursing facility, or other appropriate setting.

Use the procedure code for a house call if it is necessary for the professional's service to be provided in the member's home or place of residence because the member's condition prohibits traveling to the office. Only one house call shall be paid per pair of glasses. No payment is made for subsequent care.

Use the procedure code for an office call if:

- The member is called back to the office for a progress report, or
- The member is having minor problems and needs to be rechecked, or
- For a miscellaneous minor examination.

This procedure cannot be billed on the same date of service as any specific itemized services, e.g., eye examination, glasses, lenses, or frames. If other patients are not charged, Medicaid cannot be billed.

a. Mileage

Payment for mileage for services provided outside the office may be made under the following conditions:

- It is necessary for the optometrist to travel outside the community to visit the member, and
- There are no optometrists in the community in which the member is located.

If a charge is made for mileage, the circumstances must be noted on the claim. If more than one member is seen during the visit, only one charge for mileage will be approved.

b. Nursing Home Visits

Nursing home visits are not covered for opticians. The following policies apply to optometrist visits to skilled nursing facilities and intermediate care facilities.

Payment will usually be approved for only one visit to the same member in a calendar month. This stipulation presumes the member residing in a nursing home has a condition that makes a visit medically necessary. Payment for further visits will be made only if the optometrist adequately substantiates the need for each visit on the claim form.

When only one member is seen in a single nursing home visit, payment is based on a follow-up office visit. The reason for this policy is:

- The level of service is ordinarily comparable to that furnished in an office setting, and
- When a larger group of members is seen in a nursing home, the circumstances are much the same as if the nursing home were a second office.

In the absence of information on the claim, Iowa Medicaid Enterprise (IME) will assume that more than one member was seen. Payment will be approved on the basis of a follow-up office call.

Payment will be made for mileage in connection with nursing home visits under the following conditions:

- If it is necessary for the optometrist to travel outside the community to visit the nursing home, and
- There are no optometrists in the community in which the nursing home is located. If a charge is made for mileage, the circumstances must be noted on the claim. If more than one member is seen at the nursing home, only one charge for mileage will be approved.

6. Prior Authorization

Prior authorization is required for the following:

- A second lens correction within a 24-month period for members 8 years of age and older.

  Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or a ten-degree change in axis in either eye. When submitting the request for prior authorization, indicate the old prescription along with the current prescription.

  NOTE: New frames will be authorized only when new lenses cannot be accommodated in the current frame.

- Press-on prisms (Fresnel) may be approved when vision cannot adequately be corrected with other prisms.
- Subnormal visual aids, where near visual acuity is greater than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity, as described above, is less than 20/100. Documentation of the visual acuity must be submitted on claims for which prior approval is not required.

  Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems.

- Visual therapy when warranted by case history or diagnosis, for a period not greater than 90 days. Approved diagnoses are convergence insufficiency and amblyopies. Visual therapy for children over six years of age with amblyopia is generally considered to provide little benefit and is not cost effective. Visual therapy is not covered when provided by opticians.
- Photochromatic tint for members who have a documented medical condition that causes photosensitivity and less costly alternatives, such as clip-ons or a visor, are inadequate.

Other services, such as protective lenses for persons with only one eye, Schroeder shields, or ptosis crutches, are covered when necessary. Explanation of the need for these services shall be attached to the claim.

7. Exclusions on Coverage

Noncovered services include, but are not limited to, the following:

- Glasses with cosmetic gradient tint lenses
- Sunglasses
- Other eyewear for cosmetic purposes
- Progressive or no-line multifocal lenses
- A second pair of glasses or spare glasses
- Cosmetic surgery
- Experimental medical and surgical procedures
- Any services related to a noncovered service

C. BASIS OF PAYMENT FOR SERVICES

1. Materials

The reimbursement for allowed ophthalmic materials is subject to a fee schedule established by the Department or to actual laboratory cost, as evidenced by an attached invoice.

Materials payable by fee schedule are:

- Lenses (single vision or multifocal)
- Frames
- Case for glasses

The fees include payment of rose tints I and II. However, sunglasses, photogray, or cosmetic tinted lenses are not covered.

Materials payable at actual laboratory cost, as evidenced by an attached invoice, are:

- Contact lenses
- Schroeder shield
- Ptosis crutch
- Subnormal visual aids
- Safety frames
- Prisms

Payment for other materials is made at actual laboratory cost. Submit the actual invoice or a copy of the actual invoice issued by the optical company with your claim.

Major laboratories that provide the materials to opticians for Iowa Medicaid members must accept the Medicaid fee schedule allowances for lenses and frames provided to Medicaid members. Contact the laboratories that are currently providing materials to your practice to determine if they will accept the Medicaid fee schedule allowances. If you have an “in-house” laboratory, it must accept the fixed fee.

2. Professional Services

The basis of payment for professional services is the optometrist or optician fee schedule.

D. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare’s National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Click here to refer to the current fee schedule for Optometrists.

Click here to refer to the current fee schedule for Opticians.

Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from the IME.

It is your responsibility to select the procedure code that best describes the item dispensed. A claim submitted without a procedure code and a corresponding diagnosis code will be denied.

Modifiers	Description
EP	Service provided as a result of a Care for Kids (EPSDT) examination
KX	Replacement of lost or broken frames or lenses for members with a disability over 21 years of age
LT	Left
RA	Replacement of lost or broken frames or lenses
RT	Right
VP	diagnosis of aphakia
26	Professional component
52	Technical component

Add-on Codes

The codes lists below are add-on codes and should be billed in addition to the base code for the lens. **NOTE:** Codes listed in italics with an * are not covered under the regular Medicaid policy. A Medicaid member who wishes to receive a noncovered add-on service on the list may privately pay for that service.

Code	Description
V2115	Lens lenticular bifocal
V2118	Lens aniseikonic single
V2121	Lenticular lens, single
V2215	Lens lenticular bifocal
V2218	Lens aniseikonic bifocal
V2219	Lens bifocal seg width over
V2220	Lens bifocal add over 3.25d
V2221	Lenticular lens, bifocal
V2315	Lens lenticular trifocal
V2318	Lens aniseikonic trifocal

Code	Description
V2319	Lens trifocal seg width > 28
V2320	Lens trifocal add over 3.25d
V2321	Lenticular lens, trifocal
V2710	Glass or plastic slab off prism
V2715	Prism lens or lenses
V2718	Fresnell prism press-on lens
V2730 *	Special base curve
V2744	Tint photochromatic lens or lenses
V2745 *	Tint, any color, solid or grad
V2750 *	Anti-reflective coating
V2755 *	UV lens or lenses
V2756	Eyeglass case
V2760 *	Scratch resistant coating
V2780 *	Oversize lens or lenses
V2781 *	Progressive lens
V2782	Lens, 1.54-1.65 p/1.60-1.79g (Hi-index)
V2783	Lens, >= 1.66 p/>=1.80 g (Hi-index)
V2784	Lens polycarb or equal
V2786 *	Occupational multifocal lens
V2797	Vision supply or service

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for optometrist and optician providers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click here.

To view billing instructions for the CMS-1500, click here.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at: http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.