



Chapter 20

Medicaid Provider Manual

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20.1 EYE EXAMINATIONS/VISION SERVICES

20.1.1 Description

Medicaid covers eye and vision services provided by qualified optometry/ophthalmology professionals within certain limits based on recipient age. For information on glasses and contact lenses see the section about Vision Eyewear later in this chapter.

20.1.2 Amount, Duration and Scope

a) Emergency eye care, which meets the definition of an emergency medical condition, is covered for all recipients. Vision examinations and the provision of prescription lenses are covered. Cataract removal is covered for all eligible recipients.

b) An ophthalmologic exam with refraction includes:

- Determination of visual acuity
- Tonometry (routine and serial)
- Gross visual fields
- Muscle balance
- Slit lamp microscopy

c) Ophthalmoscopy is payable as a separate procedure. If done within a pre-op period, it is considered a pre-operative examination.

d) Eye examinations are considered bilateral and should be coded as a single procedure code.

Right and left or bilateral modifiers will not be paid.

20.1.3 Exclusions

a) Excluded vision services include:

- Orthoptic training
- Prescription fee
- Progress exams

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- Radial keratotomy
- Visual training
- Lasik (laser-assisted in situ keratomileusis) procedures

b) All charges for drugs and supplies used in the office for testing are included in the fee for the specific procedure; no additional allowance for the drugs will be made.

20.1.4 Limitations**20.1.4.1 Screening**

Refractions without eye examinations that do not result in either a need for corrective lenses or a change in corrective lenses are limited to once in a 12-month period for individuals under age 21 and once in a 24-month period for adults age 21 and older. Visits done more frequently are payable when indicated by symptoms or medical condition.

20.1.4.2 Refraction and Ophthalmology Services

Claims for refraction (92015), gonioscopy (92020), sensorimotor examination (92060), and serial tonometry (92100) that are submitted with an intermediate or comprehensive eye examination for the same date of service will be denied as inclusive in the eye examination. 92015, 92020, 92060, and 92100 are separate procedures and CPT rules on separate procedures are applicable.

20.1.4.3 Cataracts

a) Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

- Visual acuity that cannot be corrected by lenses better than 20/70 and is reasonably attributable to the cataract; or
- In the presence of complete inability to see the posterior chamber, vision is confirmed by potential acuity meter (PAM) reading, or
- For eligible recipients who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist is obtained.

b) Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the recipient will achieve improved visual functional ability when visual rehabilitation is complete.

c) Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures or the recipient's medical status.

d) The global period covers 45 days post-operative follow-up and one pre-operative day on the day of surgery. A separate professional fee will be allowed for evaluation prior to the procedure.

e) Intraocular lenses are covered if FDA approved for reimbursement, covered by Medicare, and NOT included in the ASC facility service fee. Presbyopia correcting and astigmatism correcting intraocular lenses are not covered.

20.1.4.4 Corneal Transplants

a) Indications for penetrating keratoplasty are:

- Corneal opacification that sufficiently obscures vision through the anterior segment of the eye with at least light perception present. Causes for this problem include:

1) Corneal injury and scarring;

2) Corneal degeneration (from Fuch's or other dystrophy or from previous cataract and/or intraocular lens implantation);

3) Corneal degeneration from keratoconus or familial causes;

4) Corneal infection (e.g., herpes)

- Therapeutic graft for relief of pain is needed and the patient has at least light perception vision present or the patient has corneal degeneration due to an eye inflammation resulting in pain however useful vision is still present.

b) Indications for lamellar keratoplasty include:

- Superficial layer corneal scarring and deformity due to trauma, degeneration, infection, or congenital deformity (anterior);

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- Aphakia
- High myopia
- High refractive error
- Keratoconus
- Recurrent pterygium

c) Additional conditions and limitations for corneal transplants are:

- There is no intractable glaucoma in the eye under consideration.
- There is no active eye infection at the time of surgery.
- There are no general medical contraindications to surgery or anesthesia.
- There is an informed consent obtained from the patient or patient's representative.
- There is no age restriction.

20.1.4.5 Vitrectomy

When two ophthalmology procedures that include vitrectomy are performed in the same operative session, vitrectomy will be reimbursed only once. This affects the following CPT codes:

Code	Description
67108	Repair of retinal detachment with vitrectomy, any method with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
67036	Vitrectomy, mechanical, pars plana approach
67038	Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping
67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation

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- *If 67108 and 67038 are billed on the same date of service, the claim will be reimbursed as follows:*
- 67108 is paid in full as the first of multiple procedures performed since the allowance for this procedure is greater than the allowance for 67038.
- 67038 - Since vitrectomy is included in 67108, the vitrectomy portion of 67038 is subtracted and only the epiretinal membrane stripping is reimbursed
- If 67108 is billed with 67039 or 67040, only 67108 will be reimbursed since 67039 and 67040 are included in 67108.
- If 67038, 67039 and/or 67040 are billed on the same date of service, vitrectomy is reimbursed only once. For example, if 67038 and 67040 are billed together, the claim will be paid as follows:
 - 67040 is paid in full
 - 67038 - Since vitrectomy is included in 67040, the vitrectomy portion of 67038 is subtracted and only the epiretinal membrane stripping is reimbursed

20.1.5 Authorizations

Prior authorization is not required.

20.1.6 Claims Submittal

Claims for vision services must be billed on a CMS (formerly HCFA) 1500 form. Please attach the Certification of Vision Services and Supplies form found in Appendix 6 to the claims form.

20.2 VISION EYEWEAR

20.2.1 Description

The charges incurred in dispensing visual aids prescribed by ophthalmologists or optometrists are covered by the Medicaid program. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments.

20.2.2 Amount, Duration and Scope

The following are covered:

a) Eyeglasses

- Refractive correction criteria for an original prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 1 vertical or 5 horizontal prism diopters for each eye.
- Refractive correction of a change in prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 6 degrees in cylinder axis for both eyes.
- Glass or plastic lenses may be used. Glass must conform to standard Z-80 (National Bureau of Standards) as it existed on September 15, 1983. Polycarbonate lenses must be prior authorized.
- Nose pads and rocking pads are considered as part of the technical servicing for the complete glasses. Replacement of the pads is considered a repair and is payable. Frame adjustment, verification of prescription and dispensing of eyeglasses and technical servicing is included in the servicing of the entire glasses. **Effective October 16th, 2003 use the national HCPCS code V2799 U1 when billing nose pads. Regardless of the date the claim is submitted to Med-QUEST for payment, nose pads provided on dates of service before October 16th, 2003 should be billed with local code Z9415.**
- **Eyeglasses cases – covered once every six months. Effective October 16th, 2003 use the national HCPCS code V2799 U2 when billing eyeglasses cases. Regardless of the date the claim is submitted to Med-QUEST for payment, eyeglasses cases provided on dates of service before October 16th, 2003 should be billed with local code Z9416.**
- Frames are covered. Recipients may not pay the difference between the maximum Medicaid allowance for frames and higher-priced frames. Recipients desiring more expensive frames must pay the entire charge for the frame including technical servicing of the frames. Providers may bill Medicaid only those charges pertaining to the lenses.

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- Keratoconus in one or both eyes where corrected vision by glasses is less than 20/40 and the vision is further improved by contact lenses;
- Corneal astigmatism in one or both eyes greater than 4.00 diopter correctable by contact lenses and the astigmatism correctable by contact lenses;
- Irregular astigmatism due to corneal imperfection where corrected vision by glasses is less than 20/40 and vision is further improved by contact lenses;
- Anisometropia due to aphakia or other causes where the vision corrected by glasses in the non-affected eye is less than 20/50, the problem either will last for at least six months or is permanent, and the person requires binocular vision for educational or job purposes;
- Bilateral aphakia when a person becomes ill using spectacle glasses or when the person's occupation makes the wearing of glasses hazardous;
- Certain inflammatory conditions of the cornea for which therapeutic contact lenses are indicated with the recommendation of an ophthalmologist.

c) Miscellaneous Vision Supplies

- Prosthetic eyes are covered. A global fee includes payment for all visits, materials, costs, modifications or replacement because of poor fit or unacceptable defect within 90 days from the initial visit for fitting. Neighbor Island recipients requiring a prosthesis should be referred to a provider who can complete the prosthesis in one series of daily visits.
- Subnormal visual aids are covered.

d) Repairs

Minor repairs are covered.

20.2.3 Exclusions

- Blended bifocals
- Bifocal contact lenses
- Spare pair of glasses or contacts
- Repairs on glasses that no longer meet a recipient's needs are not payable
- Tinted lenses for cosmetic reasons, recipient must pay for all expenses (technical and material)

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- Oversized lenses unless authorized for cosmetic reasons
- Contact lenses for:
 - 1) Elderly persons beyond the working age with aphakia where the corrected vision in the non-aphakia eye with glasses is 20/50 or better and the addition of a contact lens will not make the person economically productive; and
 - 2) Solely cosmetic purposes such as obscuring an opaque pupil.
- Contact Lens Care Kit and Accessories (Aseptron)
- All services or material not in compliance with the restrictions in this Chapter

20.2.4 Limitations

No prior authorization is required IF the quantity provided and claim do not exceed the limits as reflected in the table and supplier abides by special circumstances as required in HAR 17-1737-76.

a) Eyeglasses

- New lenses are limited to once in a 24-month period for adults and once in a 12-month period for individuals under the age of 21 years. A new pair within the 24-month period for adults (12 months for children) is payable if the change in prescription meets the guidelines described above under “Eyeglasses”. The 24-month period will begin again from the date of the most recent dispensed glasses. The claim for the new glasses, however, must have both the old and new prescriptions to confirm the prescription change and avoid processing delays.
- Bilateral plano glasses are payable as safety glasses for persons with one remaining functioning eye.
- Balance lenses are payable if the other eye has a prescription that meets the criteria for lenses.
- Persons with presbyopia who require minimal or no distance correction are to be fitted with ready-made half-glasses and not bifocals.
- When unusual complications affect normal recovery, ready-made temporary glasses should be rented or purchased following cataract extraction (with or without insertion of an intra-ocular prosthetic lens) until the eyes have healed and refractive error has stabilized. Authorization on Form 1144 is required except when prescribed by an ophthalmologist whose full name must appear on the claim. No additional allowance for plastic cataract lenses is payable. Payment will be made at the level for standard cataract lenses.

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- Providers may designate a selection of frames for Medicaid recipients to choose from and recipients desiring more expensive frames will be required to pay the entire charge for the frame including technical servicing of the frames. Medicaid would then only pay for those charges pertaining to the lenses. Recipients may not pay the difference between the maximum Medicaid allowance for frames and higher-priced frames.
- Trifocals are payable only for recipients currently wearing them satisfactorily and for specific job requirements.
- Tinted or color-coated corrective lenses or clip-ons do not require prior authorization in the following: aphakia, albinism, glaucoma, or other medical conditions of the eye exclusive of photophobia not associated with such conditions. The light transmission shall be adequate to permit use indoor and at night. Tinted lenses will be covered when prior authorized for those members who have non-surgically corrected cataracts.
- Repairs are payable only for current eyewear.

b) Contact lenses are only covered for the following conditions:

- Keratoconus in one or both eyes where corrected vision by glasses is less than 20/40 and the vision is further improved by contact lenses.
- Corneal astigmatism in one or both eyes greater than 4.00 diopter and the astigmatism is correctable by contact lenses.
- Irregular astigmatism due to corneal imperfection where corrected vision by glasses is less than 20/40 and vision is further improved by contact lenses.
- Anisometropia due to aphakia or other causes where the vision corrected by glasses in the non-affected eye is less than 20/50; the problem either will last for at least six months or is permanent, and the person requires binocular vision for educational or job purposes
- Bilateral aphakia when a person becomes ill using a spectacle glasses or when the person's occupation makes the wearing of glasses hazardous.
- Certain inflammatory conditions of the cornea for which therapeutic contact lenses are indicated with the recommendation of an ophthalmologist

See section above.

c) Professional codes

The following professional codes do not require prior authorization if within stated limits:

Code	Description	Limits	Pa Required
92340	Fitting of spectacles, except aphakia, monofocal	1 per yr	No
92341	Fitting of spectacles, except aphakia , bifocal	1 per yr	No
92342	Fitting of spectacles, except aphakia, multifocal, other than bifocal	1 per yr	No
92352	Fitting of spectacle prosthesis for aphakia, monofocal	1 per yr	No
92353	Fitting of spectacle prosthesis for aphakia, multifocal	1 per yr	No
92354	Fitting of spectacle mounted low vision aid, single element system	1 per yr	No
92355	Fitting of spectacle mounted low vision aid, telescopic or other compound lens system	1 per yr	No
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	1 per yr	No
92370	Repair and fitting spectacles, except aphakia	1 per yr	No
92371	Repair and fitting spectacle prosthesis for aphakia	1 per yr	No

20.2.5 Authorizations

a) Eyeglasses

- Bifocal lenses for recipients under 40 years of age must have medical justification. No additional payment is made for blended bifocals.
- Polycarbonate lenses must be prior authorized
- Replacement of children's glasses that are lost, stolen or severely damaged within 12 months of the last pair must be approved before being dispensed.

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- Replacement of an adult's glasses within two years must be approved before being dispensed. The information should include one or more of the following information:

- 1) The date and circumstances of loss;

- 2) The date the previous glasses were made; and

- 3) The visual acuity without and with corrections; or

- 4) The refractive prescription and the previous prescription, if a change is being requested.

- Replacement of lens or frames or any other part of the glasses does not require authorization.
- Ready-made glasses not prescribed by an ophthalmologist after cataract extraction.

b) Contact lenses

- A sterilization unit for soft contact lenses must be medically justified.
- All contact lenses must be authorized except for those with a change in prescription during the 24 month period in which the last pair was received does not require authorization or meet the above guidelines. Dispensing of the lenses from the new prescription begins a new 24-month period.

c) Miscellaneous vision supplies

- Initial and replacement prosthetic eyes must be prior-authorized.
- Subnormal visual aids costing more than \$50 must also be prior-authorized.

20.3 HEARING SERVICES

20.3.1 Description

Services for individuals with hearing disorders means diagnostic, screening, preventive, or corrective services/equipment/supplies provided by, or under the direction of, a physician or an audiologist, to whom a patient is referred by a physician.

20.3.2 Amount, Duration and Scope

a) A physician may prescribe audiology services for patients with hearing disorders who are expected to improve in a reasonable period of time with therapy. For speech therapy for clients with or without hearing disorders see Chapter 17 on Rehabilitative Therapy Services

b) All recommended auditory therapy shall require prior authorization by the department's medical consultants. Prior authorization requests should be accompanied by:

- The evaluation and results of standardized objective tests; and
- A plan of therapy with goals and time frames.

c) If a reasonable doubt exists that an individual requires therapy or continuation of therapy, a board of experienced therapists may be asked to review the medical consultants' findings and make recommendations to the department's medical consultants.

20.3.3 Limitations

a) Audiology. Services must be prescribed by a physician and provided by an audiologist authorized to participate in the Medicaid Program. Prior authorization for an evaluation for and request for approval of a hearing aid is required and must be requested by an otolaryngologist. Hearing aid rental and purchase requires prior authorization. The authorization request must be accompanied with the results of a hearing aid evaluation.

b) Ear Plugs. Custom-made earplugs must be prescribed by ENT specialists for individuals with recurrent middle ear infections and approved on Form 1144.

c) Hearing Aids

The following hearing aid services and items are covered without prior authorization when specific requirements, medical necessity, and quantity limits are met.

Code	Modifier	Description	Limits
92590		Hearing aid examination and selection; monaural	1 per 3 years
92591		Hearing aid examination and selection; binaural	1 per 3 years; recipients under 21 years of age
92592		Hearing aid check; includes electroacoustic evaluation; monaural	2 per 12 months
92593		Hearing aid check; includes electroacoustic evaluation; binaural	4 per 12 months for children ages 3 years and under; 2 per 12 months for children ages 4 and older
V5011		Fitting/orientation/checking of hearing aid (to follow initial hearing aid exam and selection)	Only for use when a new hearing aid is purchased and fitted
V5298		ADULTS Digital or analog	For hearing aids with a properly completed Certification Form and required attachments attached to a hard copy (paper) claim form (see below)
V5253		CHILDREN: Digital or analog	For hearing aids with a properly completed Certification Form and required attachments attached to a hard copy (paper) claim form (see below)
V5014		Analog repairs of aid not covered by warranty	Adults: 1 in 3 years Children: 2 in 3 years

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V5014	U1	Digital repairs of aid not covered by warranty	Adults: 1 in 3 years Children 2 in 3 years
V5267		Hearing aid supplies/accessories	Supplies/accessories are reimbursed at invoice amount

Hearing aid manufacturers, Phonak and Oticon, have extended special Medicaid pricing for selected hearing aids provided to Hawaii Medicaid clients by audiologists and other hearing aid suppliers. Providers should contact Phonak or Oticon for the models that qualify for the special Medicaid pricing. The special pricing includes the following:

- Ninety (90) day trial period. (Thus, billing for hearing aid rental –trial period-- will not be covered);
- Three (3) year service, loss, and damage warranty including a one time replacement during the 3-year warranty period;
- Initial hearing aid kits of children, including battery tester, stethoscope, hearing aid clips, and dehumidifier. (For initial kits for adults, contact Phonak or Oticon);
- No shipping and handling charges for all new devices, repairs, and replacements.

Although prior authorization is not needed for the processing of Phonak and Oticon hearing aids submitted under codes V5298 and V5253, the following requirements must be met:

- A hard copy (paper) claim with the following attachments must be submitted to Medicaid’s Fiscal Agent
- A completed “Certification Form” signed and dated by an audiologist
- The “ENT Medical Clearance Form” signed and dated by a Medicaid participating otolaryngologist
- The audiological results that reflect amplification readings demonstrating medical necessity
- Serial numbers of hearing device(s)
- Manufacturer’s invoice for the device, accessories and/or service.

Hearing aids, which require prior authorizations are discussed more fully in the next section below and include:

- In the Ear (ITE) hearing aids for adults
- Binaural hearing aids for adults

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- Specialty hearing aids which fall outside the stated capped price or time frequency. V5261 is to be used on a case-by-case basis for specialized hearing aid models requiring prior authorizations.

The following conditions and limitations shall apply:

- Persons requesting hearing aids shall have a hearing evaluation by a physician who is an ear, nose, and throat specialist who has determined that the otologic disorders are associated with hearing loss. Hearing Aid Suppliers will not be paid for a hearing evaluation.
- See table above for limits on frequency of hearing aid examination and selection.
- Patients requiring batteries should pick them up in person; if the patient is a resident in a SNF or ICF, the batteries should be mailed by the supplier and the postage will be paid. Service calls are not covered and not reimbursable.
- Replacement hearing aids may be provided every three years. Authorization is required for replacements before three years.
- A maximum fee for monaural hearing aids is payable. If the cost is greater than the maximum fee then an invoice from the laboratory or supplier showing the cost must be attached to the authorization form for consideration by the medical consultant.

20.3.4 Authorizations

a) The following hearing aid related items shall require medical approval by the Medical Consultant on Form 1144.

- In the Ear (ITE) and Binaural hearing aids for adults and Binaural hearing aids for children over 12 years of age:
 - ITE and binaural hearing aids for adults are generally not covered. If either an ITE model or binaural aids is needed for adult or child over 12 years of age, medical justification to support the request is required. "Special Consideration" must be written on the request and attached documentation must include an otolaryngologist evaluation and results of audiological testing.
- Specialty hearing aids and/or hearing aids from manufacturers other than Phonak/Oticon that are not comparable to the models for which special pricing applies
 - Documentation of the medical need of the specialty hearing aid, the model number, name of manufacturer, and a copy of the invoice amount on the manufacturer's letterhead.

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- Hearing aid replacements during the warranty period or within 3 years of the purchase or replacement of another hearing aid
 - Hearing aids when special Medicaid pricing is not applicable
If the manufacturer is not Phonak/Oticon, the hearing aid supplier must submit documentation that the model requested is comparable to Phonak/Oticon and a copy of the invoice amount on manufacturer's letterhead. If found comparable, Medicaid reimbursement at the special hearing aid pricing rates will be extended.
 - Hearing Aid Trial
Most manufacturers offer a "trial" period for new hearing aids. If the manufacturer does not offer this benefit, a prior authorization request with the modifier "RR" should be submitted. The supplier must submit information to justify why the trial period is needed, the name of the manufacturer, the model name and serial number and the manufacturer's policy related to a "trial" period.
 - Initial Hearing Aid Kits that are not included in the price of the hearing aid(s)
If the manufacturer does not include these in the purchase price of hearing aid(s), documentation to this effect and the invoice cost of the kits on the manufacturer's letterhead must be submitted with the authorization.
 - Hearing Aid Insurance
If prior authorized, hearing aid insurance is covered for children under age 21 years of age. Hearing aid insurance must be comprehensive and provide at least one new hearing aid for all losses and cover the labor and material costs of all damages. On a case by case basis, Medicaid may approve comprehensive loss and damage insurance beyond the expiration date of the manufacturer warranty for Medicaid clients less than 21 years of age.
- b) Prior authorization is required for cochlear implants and associated diagnostic and therapeutic services
- c) Prior authorization is required for all augmentative communication devices and related therapeutic and diagnostic services.
- d) For hearing aid purchases and services requiring prior authorizations, the following must be submitted for review:
- A fully completed prior authorization form (Form 1144);
 - An ENT physician evaluation;
 - Audiology reports that demonstrate medical necessity;

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- Medical justification for all hearing aid models that continue to require prior authorization;
- Evidence of special Hawaii pricing or manufacturer's best price invoice amount, if other than Phonak or Oticon (must be on manufacturer's letter-head). If applicable, also include justification for Medicaid payment at a higher rate than Phonak or Oticon special rates.
- Prior authorization requests including all above documentation should be sent to the Hawaii Medicaid fiscal agent, Affiliated Computer Services (ACS).

20.3.5 Claims Submittal

To expedite the processing of claims, the following instructions should be followed:

- a) If the service or hearing aid requires an approved prior authorization, the provider/supplier must bill Medicaid with the hearing aid codes and modifiers (if applicable) as they appear on the letter of approval. The prior authorization and supporting documents that were submitted will have been imaged and on file in the claims system. The provider must submit a paper claim with the following:
 - Serial numbers of hearing device(s), which will be imaged into the claims system for documentation purposes; and
 - Manufacturer's invoice for the device, accessories, or services.
- b) If the service or hearing aid does NOT require an approved prior authorization, the provider/supplier must submit a paper claim and attach the following:
 - Certification Form- signed and dated;
 - ENT Medical Clearance Form- signed and dated;
 - Audiology reports that support medical necessity;
 - Serial numbers of hearing device(s), which will be imaged into the claims system for documentation purposes; and
 - Manufacturer's invoice for the device, accessories, or service.

Claims and attachments should be submitted to the Hawaii Medicaid Fiscal Agent listed in Appendix 1.