MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Vision 03-04
(Optical Laboratory, Dispensing Ophthalmologist, Optician and Optometrist)

Issued: December 1, 2003

Subject: Vision Chapter III – Coverages and Limitations ;
Vision Forms Attachment

Effective: January 1, 2004

Programs Affected: Medicaid, Children's Special Health Care Services

Effective January 1, 2004, the Michigan Department of Community Health (MDCH) has revised the Vision Manual - Chapter III to incorporate changes required by the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, changes published in bulletins issued since the last revision, and clarification of current vision policies.

Revisions/clarifications include: the removal of the Prior Authorization requirement for eyeglasses ordered after two years from the date of the last pair of eyeglasses, clarification of MDCH glaucoma testing policy to make it clearer and more in line with other carriers, and the provision of forms for supplying information when requesting Prior Authorization for contact lens(es) and low vision devices.

Two forms have been developed for providers to use when requesting prior approval (for low vision services and aids, MSA-0891; and for contact lenses, MSA-0892) in addition to the existing Vision Approval/Order form (DCH-0893). All forms are located in the Vision Forms Attachment to this bulletin.

The Michigan Department of Community Health Contactor for Vision services is:

Classic Optical Laboratories
3710 Belmont Avenue
P.O. Box 1341
Youngstown, Ohio 44501-1341

Telephone: (888) 522-2020
Fax: (330) 759-8300

Manual Maintenance

Discard the current Chapter III and insert the attached Chapter III in your Vision Manual.

Discard Vision 01-02 (issued February 1, 2001) as this information has been incorporated in the revised Chapter III.

Discard Vision 03-02, HIPAA-Mandated Procedure Code/Modifier Changes as this information is now included in the MDCH Vision Services Database located on the MDCH website.

This bulletin may be discarded after manual maintenance is completed.

Questions

Any questions regarding this bulletin should be directed to Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration

VISION FORMS

The following forms are used by vision providers:

- Vision Services Approval/Order (DCH-0893)
- Provision of Low Vision Services and Aids Support Documentation (MSA-0891)
- Documentation of Medical Necessity for the Provision of Contact Lenses (MSA-0892)

Copies of the forms are attached.

Providers may download the forms from the MDCH website at www.michigan.gov/mdch (click on Providers, Information for Medicaid Providers, Medicaid Provider Forms and Other Resources). Copies of the forms may also be obtained from the MDCH and reproduced by the provider. To order copies of the forms, contact the MDCH at:

MDCH/Forms Distribution
Lewis Cass Building
320 S. Walnut
Lansing, MI 48933
Fax: 517-241-1164

Requests must include the form name, form number, provider name, address, and phone number, as well as a contact name.

FORM COMPLETION INSTRUCTIONS

The forms are generally self-explanatory. The following instructions are to assist in completing some portions of the DCH-0893 that may require clarification.

Items 1 – 6 are for MDCH use only.

If you are submitting the DCH-0893 to request prior approval (PA) and it is approved, the PA number will appear in Item 1 when the form is returned to you. You must use this PA number when you bill.

Items 7 – 13 are related to you and/or your employer.

Item 11 (Provider Signature) requires a hand-written signature (i.e., a stamped signature is unacceptable).

Item 13 (Date of Order) should reflect the examination date.

Items 14 – 18 contain beneficiary information which can be obtained from the **mihealth card** or, for Children's Special Health Care Services (CSHCS) enrollees, from the Provider Authorization Notice (form MG-041) or the Client Eligibility Notice (form MG-040).

Item 19 (Diagnosis) must contain the diagnosis(es) code(s) reflecting the greatest specificity for the diagnosis(es) from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). If appropriate, each eye's diagnosis(es) must be included.

Items 20 – 23 relate to services and materials being requested and applicable charges.

Lines 01 and 02 of Item 20 are preprinted. Lines 03 through 07 are available for special characteristics (e.g., prisms, high adds) or other services (e.g., contact lens, orthoptics), if applicable. **NOTE:** When billing MDCH, each date of service must be billed on a separate line; therefore, each date of service must be entered on a separate line of the DCH-0893 if the service requires PA.

Item 21 (Procedure Code) must reflect the appropriate CPT/HCPCS **procedure code and applicable modifier.**

Item 22 (Quantity) must present the appropriate quantity for each procedure code.

Each spectacle lens procedure code represents one lens. When requesting approval for, or ordering, a pair of spectacle lenses using the same procedure code, use a quantity of "2."

Item 23 (Charge) is completed only for items requiring prior approval. Enter your usual and customary charge.

Item 24 (Reason) requires you to enter an X in only one box.

Initial Eyeglasses: Enter an X if the prescription is for the **first spectacles ever worn** by the beneficiary. Both lenses and the frame must be provided.

Replacement: Enter an X if an **identical** (complete) pair of spectacles is provided because the previous pair was lost, stolen, or broken beyond repair. **NOTE:** If the identical style of frame is no longer available, a new **Medicaid-approved** frame style may be selected.

Diopter Change: Enter an X if the reason for a new pair of spectacles is due to a sufficient diopter change according to Medicaid's published policy.

Items 25 – 27 relate to the type/style of lenses and frame requested.

Items 28 – 29 reflect the lens specifications.

Enter all lens specifications in Item 28. **NOTE:** The width and style must be consistent with the procedure code appearing in Item 21 of the DCH-0893.

Item 29 must contain any additional instructions to the contractor necessary for proper fabrication.

Item 30 must contain the specifications from the beneficiary's previous lens(es). This is applicable for diopter changes or replacements, as well as when requesting frames only. If this information is missing, the form will be returned to the provider unless documentation is submitted with a reason why this is not complete. **NOTE:** The only time this item is left blank is for initial spectacles.

Item 31 is for MDCH use only. If you are requesting PA, this area will be completed before the DCH-0893 form is returned to you.

Mailing Instructions

Prior Approval

REMINDER: PA requests should be postmarked no more than 30 calendar days from the date of examination. If beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

When requesting prior approval, the provider should make a photocopy of the completed form for their file and send the original DCH-0893 to the Vision Contract Manager at the address noted below.

MDCH Vision Contract Manager
Prior Authorization Division
PO Box 30479
Lansing, MI 48909

Upon completion of the PA process, a copy of the DCH-0893 is returned to the provider.

Ordering Instructions

REMINDER: Orders placed with the contractor must be postmarked no more than 30 days after the date of examination. If beyond the 30 days, the contractor will return the order to the provider who must explain to Medicaid why submission was delayed and request an exception from the time limit.

When placing an order with the contractor, the provider should retain a copy of the completed form for their file and send the original DCH-0893 to:

Classic Optical Laboratories
3710 Belmont Ave.
PO Box 1341
Youngstown, OH 44501-1341

Telephone: (888) 522-2020
Fax: (330) 759-8300

Michigan Department of Community Health

VISION SERVICES APPROVAL / ORDER

For MDCH Consultant Use Only

1. Prior Authorization Number

2	3	4	5	6

NOTE: Approval refers to services and does NOT guarantee beneficiary eligibility.

7. **Provider** Name (Last, First, Middle Initial)			9. Phone No. ( )	10. Provider ID Number
8. Address (No. & Street, Suite, Lot, etc.)			11. Provider Signature	12. Provider Type
City	State	ZIP Code		13. Date of Order

14. **Beneficiary** Name (Last, First, Middle Initial)			16. Sex ☐ **FEMALE** ☐ **MALE**	
15. Address (No. & Street, Apt. No., etc.)			17. Birth Date	18. Beneficiary ID Number
City	State	ZIP Code	19. Diagnosis:	

	20. DESCRIPTION OF SERVICE(S)	R	L	21. PROC. CODE	22. QUANTITY	23. CHARGE
01	Spectacle Lens(es)	☐	☐			
02	Frame	☐	☐			
03		☐	☐			
04		☐	☐			
05		☐	☐			
06		☐	☐			
07		☐	☐			

24. Reason: ***Note:*** *If prior authorization is required, attach documentation of medical necessity pursuant to Medicaid Vision Manual.*

☐ **INITIAL GLASSES** ☐ **REPLACEMENT** ☐ **DIOPTER CHANGE**

25. Lens Type:

☐ **PLASTIC** ☐ **GLASS** ☐ **POLYCARBONATE** ☐ **LENS(ES) ONLY** ☐ **FRAME ONLY**

26. Lens Style:

☐ **SINGLE VISION** ☐ **BIFOCAL** ☐ **TRIFOCAL** ☐ **HI INDEX** ☐ **CATARACT**

27. Frame Name		Manufacturer	
Color	Eye Size	Bridge Size	Temple Style & Length

LENS SPECIFICATIONS

28.	SPHERE	CYLINDER	AXIS	PRISM POWER & BASE DIRECTION	MRP HORIZONTAL	MRP HEIGHT
R						
L						

	ADD	SEGMENT HEIGHT	WIDTH & STYLE	SEGMENT INSET	TOTAL INSET	PD
R						Far:
L						Near:

29. Special Instructions to Laboratory:

PREVIOUS LENS SPECIFICATIONS

30.	SPHERE	CYLINDER	AXIS	ADD	PRISM / DIRECTION	LENS STYLE
R						
L						

31. ***For MDCH Consultant Use Only***

☐ **Approved** ☐ **Disapproved -** Exceeds Frequency ☐ **No Action**

☐ **Amended** ☐ **Disapproved -** Criteria Not Met ☐ **Insufficient Documentation**

Initials and Date

Authority: Title XIX of the Social Security Act

Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

DCH-0893 (Rev. 12/03) (W) Previous Edition may be used.

Provision of Low Vision Services and Aids
Support Documentation

To facilitate processing of your request for low vision services and aids, this form must be completed. Failure to provide complete documentation will result in automatic disapproval of your request. Do not use abbreviations as their use may result in misinterpretation and possible disapproval. A Version Services/Order form (DCH-0893) must accompany this documentation. (Exception: High add bifocals do not require prior approval; hence, a completed DCH-0893 should be sent directly to the State's vision contractor.)

Beneficiary's Name _____ **Medicaid ID Number** _____

Based on the Low Vision Evaluation provide the following information:

A. HISTORY

1. History of onset of low vision (including, but not limited to, onset, duration, etiology, and any ocular surgery):

_____

_____

_____

_____

_____

2. Present spectacle correction:

R _____ **VA** _____ **ADD** _____ **VA** _____

L _____ **VA** _____ **ADD** _____ **VA** _____

3. Contact Lenses: (If worn)

Power R _____ **Type R** _____

Power L _____ **Type L** _____

4. Low vision aids presently in use:

Magnifiers: _____ Electronic Projection Magnifier: _____

Microscopics: _____

Telescopics: _____ Filers/typoscopes/visors: _____

Loupes: _____ Other: _____

5. Relevant Systemic Conditions:

_____

_____

_____

_____

_____

B. BENEFICIARY'S GOALS

_____

_____

_____

_____

_____

C. SUMMARY FINDINGS

1. Ocular Diagnosis(es):
   R _____ **L** _____

2. Vision Impairment Diagnosis:
   R _____ **L** _____

3. Nature and Extent of Visual Fields:

   _____

   _____

4. Specifications of best conventional spectacle correction:

At distance	**R**	_____	**VA**	_____
	L	_____	**VA**	_____
At near	**R**	_____	**VA**	_____
	L	_____	**VA**	_____

D. RECOMMENDED TREATMENT

1. No treatment at this time. Follow-up for monitoring (check one):

   ☐ 3 Months ☐ 6 Months ☐ 9 Months ☐ 12 Months

2. Referral for medical and/or surgical treatment:

   _____

   _____

3. Description of Recommended Low Vision Aids:

A. VA **R** _____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

B. VA **R** _____ **L** _____ Description, manufacturer and catalog number _____
Describe specific use:
Describe benefit:

Acquisition Cost	Professional Fee

C. VA **R** _____ **L** _____ Description, manufacturer and catalog number _____
Describe specific use:
Describe benefit:

Acquisition Cost	Professional Fee

E. OTHER RECOMMENDATIONS – DESCRIBE BENEFITS

_____

_____

_____

_____

_____

F. PROGNOSIS

_____

_____

_____

_____

Signature of Examiner _____

Examiner (Print) _____ **Date** _____

Documentation of Medical Necessity for the Provision of Contact Lenses

(This form is to be completed and attached to DCH-0893 when requesting prior authorization for the provision of contact lenses. Prior authorization is NOT required for beneficiaries with congenital or surgical aphakia who are under six years of age.).

Beneficiary's Name _____ **Medicaid ID Number** _____

Indicate the diagnosis(es) which best describes the beneficiary's condition:

- ☐ Aphakia (congenital or surgical)
- ☐ Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)
- ☐ Anisometropia or antimetropia (of 2 diopters or greater that results in aniseikonia)
- ☐ Congenital cataracts (up to six years of age)
- ☐ Other conditions with no alternative treatment (Explain)

_____

_____

Diagnosis(es) (ICD-9-CM): _____

Current spectacle correction:				**Best spectacle correction:**			
R	_____	**VA**	_____	**R**	_____	**VA**	_____
L	_____	**VA**	_____	**L**	_____	**VA**	_____
ADD	_____			**ADD**	_____		

Has the beneficiary previously worn contact lenses? ☐ YES ☐ NO
If yes, explain:

_____

_____

Is the beneficiary currently wearing contact lenses? ☐ YES ☐ NO
If yes, indicate reason for new lenses:

_____

_____

Keratometry (diopters)

R _____ @ _____ ; _____ @ _____

L _____ @ _____ ; _____ @ _____

Type of contact lens requested:

A. Hydrogels

	R	L
Power		
Series (Brand Name)		
Additional Specifications		
Manufacturer		
Manufacturer's wholesale cost		

B. Rigid Gas Permeable

	R	L
Base Curve		
Power		
Diameter		
Additional Specifications		
Manufacturer		
Brand Name		
Manufacturer's wholesale cost		

Expected obtainable visual acuity with contact lenses at distance:

R _____ **L** _____

Approximate wearing time per day (specify number of hours):_____

Are eyeglasses to be worn simultaneously, as an over-correction, with the contact lenses? ☐ Yes ☐ No

Provide your assessment of beneficiary's ability to insert, remove, maintain, and wear contact lenses:

_____

_____

_____

_____ _____

Provider's Signature **Provider's Name (Print)**

Date: _____

VISION

TABLE OF CONTENTS

SECTION 1 – GENERAL GUIDELINES AND REQUIREMENTS

The Michigan Department of Community Health (MDCH) contracts for volume purchase of frames and lenses from an optical laboratory, referred to in this chapter as the contractor.

Vision providers, (e.g., opticians and dispensing ophthalmologists, and optometrists) must order frames and lenses from the contractor. A list of lenses is available in the Vision Services Database located on the MDCH website. A list of available frames is available from the contractor, currently Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)

Orders placed with the contractor must be postmarked no later than 30 days after the date of order. If orders are placed beyond the 30 days, the contractor returns the order to the provider, who must explain to Medicaid why submission was delayed and request an exception from the time limit.

Procurement of contact lenses, low vision aids, and prosthetic eyes must be obtained from the vision provider's own source and are subject to prior authorization (PA) requirements as described in this chapter.

1.1 BENEFICIARY ELIGIBILITY AND CO-PAYMENT

Providers must verify beneficiary eligibility via the Eligibility Verification System (EVS) prior to rendering services or ordering materials. If a beneficiary's eligibility expires prior to the date the material is delivered, reimbursement is made **only** if the beneficiary was eligible on the date the material was ordered by the vision provider and the date of order is used when billing. (Refer to the Beneficiary Eligibility Chapter of this manual for further instructions and the Directory Appendix for contact information.)

A $2.00 beneficiary co-payment is required for each separately reimbursable:

- ophthalmological service performed by an optometrist or ophthalmologist; and
- Dispensing service for glasses or contact lenses billed by dispensing opthalmologists (enrolled as Provider Type 86) or optometrists.

Co-payment is not required for beneficiaries:

- Under age 21;
- Residing in a nursing facility (NF); or
- Having Medicare when Medicare covers the service.

If a beneficiary is unable to pay the required co-payment on the date of service (DOS), vision providers **cannot** refuse to render the service. However, the vision provider may bill the beneficiary the co-payment amount, and the beneficiary is responsible for payment. If the beneficiary fails to pay a co-payment, the vision provider may, in the future, refuse to serve the beneficiary as a Medicaid patient.

(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.2 Prior Authorization

Some vision services and materials require prior authorization (PA) before they can be rendered. Applicable sections or subsections in this chapter indicate whether a specific service and/or material requires PA. In addition, the Vision Services Database on the MDCH website indicates if a service/material requires PA by the status code "P". (Refer to the Directory Appendix for website information.)

The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. A copy of the DCH-0893 and completion instructions can be found in the Forms Appendix of this manual. Complete and mail or fax the DCH-0893 to Prior Authorization Division at MDCH. (Refer to the Directory Appendix for contact information.) PA requests must be postmarked no later than 30 calendar days after the date of order. If beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

When requesting prior approval, providers should make a photocopy of the completed form for the beneficiary file. Upon completion of the PA process, MDCH returns one copy of the DCH-0893 to the provider.

Forms may be electronically retrieved from the MDCH website. (Refer to the Directory Appendix for website information.) The provider may also obtain a supply of forms by sending a letter or fax specifying the form name and number, quantity desired, and shipping address to MDCH, Forms Distribution. (Refer to the Directory Appendix for contact information.)

1.3 Coding of Services

The American Medical Association's (AMA) Current Procedural Terminology (CPT) is the national coding standard for healthcare professional services. Vision providers must use CPT codes in effect on the DOS to describe and identify the services and procedures performed. Optometrists must be Therapeutic Pharmaceutical Agent (TPA) certified in order to use many of these codes.

Providers must use the International Classification of Diseases, 9th Revision, and Clinical Modification (ICD-9-CM) for diagnostic coding of diseases, injuries, and conditions. Codes must be used at the highest level of specificity.

Health Care Financing Administration Common Procedure Coding System (HCPCS) is a system developed by the Centers for Medicare and Medicaid Services (CMS) to report materials, supplies, and certain services not covered by the CPT codes. HCPCS codes are to be used when applicable.

1.4 Medicare

All vision services are subject to editing for Medicare coverage. MDCH reimburses vision providers for coinsurance and deductible amounts on Medicare-approved claims up to Medicaid's reimbursement limit.

If a service requires PA by Medicaid and is covered by Medicare, vision providers do not have to obtain PA, nor does the vision provider have to obtain lenses and/or frames through the volume purchase program.

(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.5 Contractor Guarantee

Frames and lenses furnished by the contractor are guaranteed for 60 days. If any material is found to be unsatisfactory due to contractor error or defective workmanship or materials, the materials and work order form should be returned to the contractor. The contractor is required to correct, adjust, or replace the materials.

If the vision provider supplies the contractor with incorrect specifications that results in eyeglasses being fabricated which the beneficiary cannot use, the vision provider is responsible for payment to the contractor for the remake. The contractor may not charge the vision provider more than what they would charge MDCH for the remake. MDCH does not pay for the remake (e.g., eyeglasses, lenses, or frames) due to vision provider error.

1.6 Complaint Process

To resolve problems (such as an overdue shipment, error in an order, or defective workmanship), vision providers should first contact the contractor. The current contractor is Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)

If the lenses and/or frames are not received from the contractor within 21 days from the date they were ordered, vision providers are responsible for contacting the contractor to determine the cause of the delay.

If difficulties are encountered with the contractor in resolving a problem, vision providers should call the Vision Contract Administrator. (Refer to the Directory Appendix for contact information.) Vision providers must be prepared to report the beneficiary's name and Medicaid ID number, and a detailed explanation of the problem(s) they have experienced.

MDCH reviews the complaint, takes necessary action to correct the problem, and notifies the vision provider of the resolution.

SECTION 2 – DIOPTER CRITERIA

2.1 INITIAL LENSES

Initial lenses are considered to be the first prescription lenses ever worn by a person regardless of how they were obtained (e.g., through Medicaid, other insurance, or private pay). Initial lenses are a Medicaid benefit and do not require PA if the following minimum diopter criteria are met:

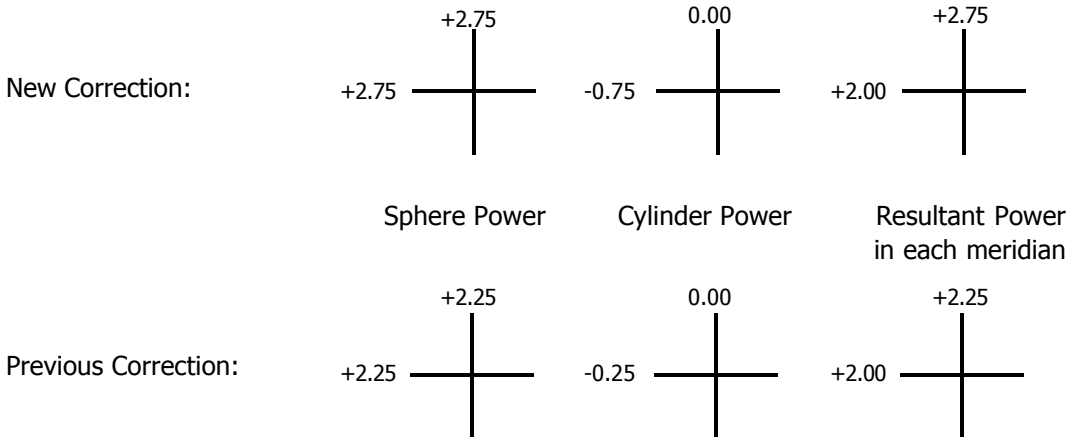
Age Group 42 Years and Younger	
▪ 0.50D myopia	▪ 0.75D anisometropia
▪ 0.50D astigmatism	▪ 0.75D hyperopia

Age Group 43 Years and Older	
▪ 0.50D myopia	▪ 0.50D hyperopia
▪ 0.50D astigmatism	▪ 0.50D presbyopia
▪ 0.75D anisometropia	

2.2 SUBSEQUENT LENSES

Regardless of age group, subsequent lenses are medically necessary lenses that are provided after initial lenses. Subsequent lenses are a Medicaid benefit and do not require PA if there is a change in the refractive error of 0.75D or more in the meridian of greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00D or more. These lenses must also meet minimum dioptric criteria as specified above. The change need only be present in one eye.

The following example illustrates how this requirement is assessed for a new correction (+2.75-0.75 ax 092) and a previous correction (+2.25-0.25 ax 090). The dioptric power in each meridian can be portrayed in the form of cross diagrams.



This is an example of where the change in dioptric power for subsequent lenses has not been met. Note that the resultant powers in the vertical meridians of the "new" and "previous" correction are +2.75 and +2.25 respectively. There is only a 0.50D change in the vertical meridian and no change in the horizontal.

For periods greater than 24 months from the date of the previous prescription, subsequent lenses may be ordered for diopter changes less than those specified above.

SECTION 3 – SERVICES

This section provides information on both Medicaid covered and noncovered services.

3.1 DIAGNOSTIC SERVICES

In providing services, it is the responsibility of the optometrist or ophthalmologist to determine that the services are medically necessary, appropriate, within the scope of current medical practice and Medicaid limitations. The prescribing optometrist or ophthalmologist is held responsible if he orders excessive or unnecessary services, regardless of who actually renders the services. The prescribing optometrist or ophthalmologist may be subject to corrective action related to these services, including recovery of funds.

Documentation Guidelines for Evaluation and Management Services, 1995, 1997, or latest version thereof, developed jointly by CMS and the AMA, must be adhered to when using the CPT/HCPCS procedure codes.

Eye Examinations	▪ A routine eye examination once every two years is a Medicaid benefit and does not require PA. Examinations include, but are not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program and disposition. (Use appropriate HCPCS procedure codes for routine eye exam.) Applicable diagnostic codes (ICD-9-CM) are 367.00 - 367.89. ▪ Nonroutine eye examinations are a Medicaid benefit for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular symptoms. (Use appropriate HCPCS procedure codes.)
Glaucoma Screenings	Glaucoma screenings are covered without PA on an annual basis for beneficiaries who: ▪ Have no ocular complaints or prior history of glaucoma and who have diabetes; ▪ Have a family history of glaucoma; or ▪ Are African-American age 50 or older. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. (Use the appropriate HCPCS procedure code for glaucoma screening.) The applicable diagnostic code is Supplementary Classification ICD-9-CM code V80.1. If the beneficiary presents with a visual or ocular complaint, the glaucoma screening code should not be used. The procedure code which best describes the visit should be selected from the CPT evaluation and Management (E/M) codes or General Ophthalmological codes.

3.2 DISPENSING SERVICES

Dispensing services are a Medicaid benefit and do not require PA. Vision providers may bill a dispensing fee for dispensing prescription lenses, prescription lenses with frames, or replacing a complete frame.

Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying, and aligning/fitting of eyeglasses as described above. Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.

3.3 Nursing Facility Beneficiaries

Covered and noncovered vision services, as well as PA requirements, apply to vision services provided to beneficiaries residing in a nursing facility (NF).

Performance of vision services (except replacement of a frame part for eyeglass repair) must be upon the written request of the beneficiary, a member of the beneficiary's family, or other beneficiary representative and upon the written order of the beneficiary's attending physician (MD, DO) prior to the date of the vision provider's visit.

If service is provided in the NF, a copy of the request and written order must be retained by the facility as part of the beneficiary's record.

Vision services are not considered a part of the facility's per diem rate. The vision provider or contractor must bill MDCH for vision services rendered.

No additional payments are made to vision providers for a visit(s) to the NF. Appropriate procedure codes must be utilized.

3.4 Ophthalmic Frames and Lenses

A complete pair of eyeglasses is a Medicaid benefit and does not require PA when:

- The eyeglasses being prescribed are the beneficiary's first pair of eyeglasses ever worn. These eyeglasses are considered to be initial eyeglasses and must meet minimum diopter criteria for initial lenses.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames are unusable.
- A previously used frame requires oversized lenses. (Oversized lenses are not a Medicaid benefit, therefore, a complete pair of eyeglasses must be ordered.)
- Prescription lenses remain usable, but the original frame is broken beyond repair and the original frame is not a Medicaid benefit.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames remain usable, but the vision provider or beneficiary elects not to send the frames to the contractor or the contractor feels that the previously used frames will break or otherwise be damaged during lens insertion.
- The beneficiary's eyeglasses have been lost, stolen, or broken beyond repair and the number of replacements have not exceeded Medicaid limits which are:
  - For beneficiaries age 21 and over, one pair of replacement eyeglasses per year.
  - For beneficiaries under age 21, two pair of replacement eyeglasses per year.

One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered.

The DCH-0893 must be used when ordering frames and/or lenses. (Refer to the Forms Appendix for additional information.) Initial or replacement eyeglasses that do not exceed Medicaid's replacement limits do not require PA. These orders must be sent directly to the contractor. Orders may be mailed or faxed. (Refer to the Directory Appendix for contact information.) The contractor fills the vision provider's order in accordance with the lens and frame specifications indicated on the DCH-0893. The order form is returned to the provider if the eligibility information is not completed.

Procedure codes that are designated with the status code "P" in the Vision Services Database on the MDCH website require PA, and must first receive approval from the Prior Authorization Division. (Refer to the Prior Authorization subsection above for instructions on obtaining PA.)

The contractor monitors orders to assure that Medicaid replacement limitations, diopter criteria, and PA requirements are being maintained. The contractor returns an order if the order exceeds the replacement limits, does not meet diopter criteria, or requires PA.

The contractor bills MDCH for the frames and/or lenses ordered by vision providers. Vision providers subsequently bill for a dispensing service for dispensing the frames and/or lenses.

If the beneficiary has other insurance that covers frames and/or lenses, the material may still be obtained through the contractor. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual when billing for the dispensing service if other insurance is involved.)

3.4.A. LENSES

Lenses must conform to the *American National Standard Recommendations for Prescription Ophthalmic Lenses, ANSI Z80.1-1999*, or the latest addition thereof.

Plastic and glass lenses are a Medicaid benefit and only require PA for lenses in the Vision Services Database on the MDCH website which have status code "P".

- Plastic and glass bifocals are available in Round 22, FT-25, FT-28, FT-35, and Executive style.
- Plastic and glass trifocals are available in FT-7x25 and FT-7x28 segments.

Photochromic, Tinted and Dyed Lenses	PA is required for these lens features. Appropriate documentation of medical necessity must be attached to the DCH-0893 when submitted to the Prior Authorization Division.
Polycarbonate Lenses	Polycarbonate lenses are a Medicaid benefit and do not require PA when diopter criteria are met and the lenses are inserted into a safety frame, marked "Z 87" or "Z 87-2".

Oversized lenses, no-line, or progressive style multi-focals are not Medicaid benefits.

3.4.B. Ophthalmic Frames

Frames must conform to the *American National Standard Requirements for the Dress Ophthalmic Frames, ANSI Z80.5-1997*, or the latest edition thereof.

Ophthalmic frame styles that are a Medicaid benefit are available from the contractor. Vision providers may order sample frames directly from the contractor. The vision provider is charged for sample frames at the same price stated in the current contract. Neither the provider nor the contractor may charge Medicaid for sample frames.

Vision providers must offer a beneficiary the opportunity to select a frame from at least 80 percent of the total authorized frame styles. A vision provider who fails to comply with this requirement is subject to termination of enrollment in Medicaid.

If a frame manufacturer discontinues production of a frame that is listed as a benefit, vision providers may utilize the discontinued frame from their sample kit. If lenses are required, they must be ordered from the contractor. Submit the DCH-0893 to the Prior Authorization Division for approval. (Refer to the Directory Appendix for contact information.)

Safety Frames	Safety frames are a Medicaid benefit. A list of authorized safety frame styles is available from the contractor. These frames conform to ANSI Z87.1-2003 standards, and samples can be purchased from the contractor at contract prices. Only polycarbonate lenses of 2 millimeter minimum thickness shall be used in frames marked "Z 87" or "Z 87-2".
Frame Repairs	Frame repairs (e.g., aligning temples, insertion of screws, adjusting frames) are not a separately reimbursable service and cannot be billed.

3.4.C. Subsequent Lenses Placed in Previously Used Frames

Subsequent lenses that are to be placed in a beneficiary's previously used frame are a Medicaid benefit and do not require PA. Previously used frames are defined as ophthalmic frames in which the beneficiary has had previous corrective lenses incorporated and which were previously worn.

All noncontract previously used frames require PA.

To order subsequent lenses for insertion into a previously used frame, vision providers must complete the DCH-0893, indicating all information necessary for proper fabrication. Vision providers have the option of having the contractor insert the lenses, in which case the provider must supply the previously used frame to the contractor, or inserting the newly fabricated lenses into the frames in their office.

If the previously used frames are sent to the contractor for lens insertion, the contractor is required to fabricate the lenses and mail the frames and lenses to the vision provider within nine working days after receiving the frames. If a special prescription requires

more than nine working days to complete, the contractor must notify the vision provider. If the provider does not receive the materials within three weeks from the date the order was sent, he should contact the contractor.

If the vision provider or beneficiary elects not to send the previously used frames as might be requested by the contractor, or if the contractor feels that the previously used frames may break or otherwise be damaged during lens insertion, the vision provider is requested to order a complete pair of eyeglasses.

If frames are sent to the contractor, either at the contractor's request or the vision provider's preference, the vision provider is responsible for paying the postage necessary to ship the frames. Also, vision providers are responsible for paying for frames lost or damaged in transit.

If a previously used frame requires lenses that are not a Medicaid benefit (e.g., oversize lenses), a complete pair of eyeglasses that are a benefit must be ordered.

3.4.D. REPLACEMENT

Eyeglasses	When ordering a complete pair of eyeglasses to replace eyeglasses that have been lost, stolen, or broken beyond repair, the eyeglasses may be ordered directly from the contractor if replacement limits have not been exceeded. The replacement eyeglasses must be an identical replacement of the previously issued Medicaid eyeglasses.
Lenses Only	Replacement of a corrective lens(es), without frames, for one that is damaged or broken is a benefit, if that lens(es) is covered by Medicaid and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or broken lens. It does not require PA. Vision providers must order the lens(es) directly from the contractor. For periods greater than 24 months from the date of the previous prescription, when ordering subsequent lenses or complete eyeglasses see Subsequent Lenses subsection above for appropriate diopter criteria.
Frames Only	Replacement of a complete frame (front and temples) is a Medicaid benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement. If an identical frame is not listed as a Medicaid benefit, the beneficiary must select a frame that is a covered benefit. The contractor bills Medicaid for the complete frame. The vision provider inserts the lenses into the frame and bills Medicaid for the dispensing service.

3.4.E. Two Pairs of Eyeglasses

Two pairs of single vision eyeglasses (one for near visual tasks and the other for distance visual tasks) are a Medicaid benefit in either of the following instances:

- When the beneficiary has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.
- When the beneficiary's physical condition does not allow bifocal usage.

PA is required when requesting two pairs of eyeglasses. Appropriate documentation must be attached to the DCH-0893 and submitted to the Prior Authorization Division.

Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a Medicaid benefit.

3.4.F. Nondeliverable Eyeglasses

If a beneficiary fails to return to the vision provider for dispensing of eyeglasses, the vision provider should make every effort to locate the beneficiary, including contacting the local Family Independence Agency (FIA) office in the beneficiary's area.

If the beneficiary still cannot be located, the eyeglasses should be sent to the local FIA office (or local nonprofit agency if the FIA office refuses to accept them) in the beneficiary's area within 90 days of placing the order with the contractor. Do not send the nondelivered lenses and/or frames to MDCH unless requested to do so by MDCH.

To bill for dispensing, the provider must use the date of order for the lenses and/or frames.

Medicaid does not reimburse vision providers for postage and handling.

3.4.G. Eyeglass Case

One eyeglass case for every complete pair of eyeglasses ordered is a Medicaid benefit and must be provided by the contractor. Vision providers cannot bill for eyeglass cases.

3.5 Low Vision Services

Evaluation	A low vision evaluation is a benefit when the beneficiary presents with moderate visual impairment, severe visual impairment, or profound visual impairment as defined in the ICD-9-CM. Under these conditions, a low vision evaluation does not require PA. This evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of beneficiary; and advice to family (if appropriate). The CPT E/M or General Ophthalmology procedure code which best describes this service should be utilized.

Aids	High add bifocals do not require PA. For high add bifocals, complete the DCH-0893 and submit to the contractor. The prescription and fitting of low vision optical aids (such as telescopes, microscopes, and certain other low vision aids) require PA. **Only basic and essential low vision aids are a Medicaid benefit.** The Provision of Low Vision Services and Aids Support Documentation (MSA-0891) form outlines the information required when requesting PA for low vision services and aids. A sample of this form is provided in the Forms Appendix. It can also be obtained through the MDCH website. (Refer to the Directory Appendix for website information.) This form must be attached to DCH-0893 and submitted as part of the PA process. (Refer to the Prior Authorization subsection above.) Reimbursement for a low vision aid is based on the manufacturer's charge for the aid plus a professional fee. Procurement of the low vision aid is done through the vision provider's own source. The professional fee includes procurement, verification, and fitting of the aid. Only an optometrist or a dispensing ophthalmologist can bill for a low vision aid. A dispensing ophthalmologist must be enrolled as a Provider Type 86.
Rehabilitative Services	Low vision rehabilitative services include instructions, training, and assistance to the beneficiary in the most effective use of the low vision aid. Documentation for these services should be included when requesting the low vision aid.

3.6 CONTACT LENSES

Evaluation	A comprehensive contact lens evaluation is a Medicaid benefit and does not require PA when the beneficiary presents with one of the following conditions and visual performance is expected to be significantly improved with the application of a contact lens(es): (Use appropriate HCPCS comprehensive contact lens evaluation code.) ▪ Aphakia (congenital or surgical) ▪ Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses) ▪ Anisometropia or Antimetropia (of two diopters or greater that results in aniseikonia) ▪ Congenital cataracts up to age six ▪ Other conditions which have no alternative treatment
Prescription and Fitting	The prescription and fitting of contact lenses is a Medicaid benefit and requires PA, except for beneficiaries under age six with a qualifying diagnosis. ▪ The prescription of contact lenses requires the complete description of contact lens specifications. ▪ Fitting includes the supply of contact lenses, verification of lens characteristics, carrying case, solutions, instructions, training, and incidental modification of the lenses during the three-month adaptation period. Procurement of contact lenses is to be done through the vision provider's own source.

	The Documentation of Medical Necessity for the Provision of Contact Lenses (MSA-0892) form outlines the information required when requesting contact lens PA. A sample of this form is provided in the Forms Appendix and can also be obtained through the MDCH website. (Refer to the Directory Appendix for website information.) This form must be attached to the DCH-0893 and submitted to MDCH as part of the PA process. (Refer to Prior Authorization subsection above.) **One contact lens replacement in a year for each eye is allowed for beneficiaries age 21 and over. Two replacements in a year are allowed for each eye for beneficiaries under age 21.** (One year is defined as 365 days from the date the first pair of contact lenses [initial or subsequent] was ordered.) Except as indicated previously, contact lens supplies (e.g., wetting and cleaning solutions, carrying cases) are not Medicaid benefits.

3.7 STRABISMUS AND / OR AMBLYOPIA EXAMINATION

Strabismus and/or amblyopia examination (sensorimotor examination) is a Medicaid benefit and does not require PA.

3.8 ORTHOPTICS AND / OR PLEOPTICS TRAINING

Orthoptics and Pleoptics Training	Orthoptics and pleoptics training are Medicaid benefits only when there is a diagnosis of exotropia, esotropia, heterotropia, strabismus, or amblyopia exanopsia. ▪ For beneficiaries under age 21, PA is not required. ▪ For beneficiaries age 21 and over, PA is required. When requesting PA, the following documentation must be attached to the DCH-0893 and submitted to the Prior Authorization Division: ▪ Visual acuity, each eye, with best spectacle correction; ▪ Magnitude and direction of the subjective and objective angle of strabismus at distance and near; ▪ Refractive error of each eye; ▪ Degree of fusion; ▪ History of strabismus, including onset, duration, prior treatment; and ▪ Other relevant information. In addition to the above documentation, a detailed plan indicating the training procedures and equipment to be employed, frequency of office visits, home training aids, and prognosis must be attached to DCH-0893. This training plan may be authorized for a period of up to three calendar months. If continued training beyond the period that was authorized is necessary, a new request for PA must be submitted with the following information: ▪ Update of the above-listed items; ▪ Report of the results of previous training; and ▪ Indication for further treatment with a detailed plan.

Orthoptic Training Aids	Orthoptic training aids are a Medicaid benefit when incorporated in an orthoptics or pleoptics training plan (as described above) and require PA. The following documentation must be included with the vision provider's detailed plan when requesting the purchase of an aid: ▪ How the aid is to be used; ▪ Complete description of the aid; ▪ Name of the manufacturer; and ▪ Manufacturer's charge. Reimbursement for a training aid is based on the manufacturer's charge to the vision provider plus a professional fee. The professional fee includes procurement, instruction in use, and fitting when applicable. Procurement of the training aid is done through the vision provider's own source. Purchase of orthoptic training aids must be billed only by an optometrist or dispensing ophthalmologist enrolled as a Provider Type 86.

3.9 PROSTHETIC EYES

A prosthetic eye (plastic/custom) or shell is a Medicaid benefit and does not require PA.

For an enlargement or reduction of an ocular prosthesis, PA is required. PA is also required when requesting a prosthesis other than a plastic/custom eye. When requesting PA, the DCH-0893 should be completed with documentation attached and submitted to the Prior Authorization Division. Procurement of the prosthesis should be obtained from the provider's own source.

Reimbursement for a prosthesis is made on a per case basis which includes, but is not limited to:

- Trial fitting
- Supply of prosthesis
- Solutions
- Training in insertion and removal
- Instruction in care
- Subsequent office visits to achieve maximum wearing time and optimal cosmetic fit
- Any necessary modification during the adaptation period of six months