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CHAPTER SEVENTEEN

EYE CARE SERVICES

Chapter 17 Eye Care Services

Rule No. 560-X-17-.01 Eye Care Services - General

The information contained herein sets forth policies and procedures for providing eye care services under the Alabama Medicaid Program.

(1) Participation. Only in-state and borderline out-of-state eye care services providers (within a 30-mile radius of the state line) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The following information must be included in a written enrollment request to Medicaid's Fiscal Agent, Provider Enrollment Division:

1. Name
2. Address
3. Specialty Provider Type
4. Social Security Number
5. Tax Identification Number
6. Medical or Business License Number, as applicable

(2) Patient Identification

It is most important that a provider verify a Medicaid recipient's identity and eligibility, since claims submitted on ineligible persons cannot be paid by the Alabama Medicaid Agency (Medicaid). Refer to Chapter 1, General, of this Code for information about identification of Medicaid recipients.

(3) Prior Authorization

Certain services require prior authorization. Refer to Chapter 15 of the Alabama Medicaid Provider Manual.

Author: Calvin Binion, Associate Director, State Agency, Vision, & Clinic Services
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. § 401, et seq.
History: Rule effective October 1, 1982. Amended May 9, 1984; January 13, 1988; January 13, 1993; March 13, 1993. Amended: Filed January 18, 2012; effective February 22, 2012. **Amended:** Filed July 12, 2018; effective August 27, 2018.

Rule No. 560-X-17-.02 Physician Services for Diseases, Injuries, or Congenital Defects

(1) If medically necessary, treatment may include contact lenses (for keratoconus, aphakia, high magnification difference between lenses), when requested in writing and prior authorized by Medicaid.

(2) Orthoptics (eye exercises) must be prior authorized by Medicaid. Full information justifying medical necessity (including number of sessions anticipated) must be sent in writing to Medicaid before this service is begun.

(3) Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury.

Author: Jacquelyn King, Program Manager; Medical Support
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. § 401, et seq.
History: Rule effective October 1, 1982. Amended May 13, 1993
Amended: Filed January 18, 2012; effective February 22, 2012.

Rule No. 560-X-17-.03 Optometrist Services

(1) Services That May be Provided Other Than Correction of Refractive Error.

(a) In the conduct of an optometric eye examination, if the optometrist suspects or detects abnormalities or irregularities requiring medical treatment the case will be referred to an appropriate doctor of medicine or osteopathy.

(b) If medically necessary, contact lenses (for keratoconus, aphakia, high magnification difference between lenses), may be provided when prior authorized by Medicaid.

(c) Orthoptics (eye exercises) must be prior authorized by Medicaid. Full information justifying medical necessity (including number of sessions anticipated) must be sent in writing to Medicaid before this service is begun.

(d) Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury.

(e) Photochromatic lenses may be prior authorized when justified in writing.

(f) Post-operative cataract patients may be referred by the ophthalmologist, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Any subsequent abnormal or unusual conditions diagnosed during follow-up care shall be referred back to the ophthalmologist. When submitting claims the appropriate modifier identifying post-operative management must be utilized. If the ophthalmologist receives payment for the global amount the post-operative claim will deny. No post-operative management claim will be processed until referring ophthalmologist has received payment for surgery. It shall be the responsibility of the optometrist to confer with the ophthalmologist for appropriate claim corrections and/or submissions.

(2) Examination for Refractive Error Only.

(a) A complete eye examination and work-up is required and will include the following: case history, eye health examination, visual acuity testing, visual fields (if indicated), tonometry, prescribing eyeglasses (if indicated), and determining optical characteristics of lenses (refraction).

(b) For children, examination of eye tension and visual fields should be performed only if indicated.

(c) Medicaid recipients twenty-one (21) years of age and older are authorized one (1) complete eye examination and work-up every two (2) calendar years; recipients under twenty-one (21) years of age are authorized two (2) complete eye examinations and work-ups every calendar year or more often if medical necessity is documented.

(d) Diagnosis will be indicated as refractive error findings.

(e) Services rendered to Medicaid recipients while confined to bed in a health care facility may be rendered as long as it is documented by the patient's assigned physician that the patient is unable to leave the facility and the examination is medically necessary.

(3) If eyeglasses are required and provided, services will include verification of prescription, dispensing of eyeglasses (including laboratory selection), frame selection, procurement of eyeglasses, and fitting and adjusting of eyeglasses to the patient.

Author: Elizabeth Huckabee, Program Manager; Physician and EPSDT Unit
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. §§ 435.520(3), 441.30 (a)(b); State Plan, Attachment 3.1-A, page 2.2, 5.1.
History: Rule effective October 1, 1982. **Amended:** effective June 8, 1985. **Emergency rule:** effective December 1, 1986. **Amended:** effective March 12, 1987; March 13, 1993. **Emergency Rule:** Effective April 15, 1993. **Amended:** May 11, 1993. **Amended:** Filed January 18, 2012; effective February 22, 2012. **Emergency Rule:** Filed and Effective June 1, 2012. **Amended:** Filed July 12, 2012; effective August 17, 2012. **Amended:** Filed June 21, 2021; Effective August 14, 2021.

Rule No. 560-X-17-.04 Eyeglasses

(1) Authorization

(a) Recipients under 21 years of age are authorized two pair of glasses each year if indicated by an examination; a prior authorization will be required for subsequent pairs requested in a calendar year. Recipients 21 years of age and older are authorized one pair of eyeglasses every two calendar years if indicated by an examination; a prior authorization will be required for subsequent pairs requested within two calendar years. These limitations also apply to fittings and adjustments.

(b) Additional eyeglasses which are medically necessary may be prior authorized by Medicaid for treatment of eye injury, disease or significant prescription change.

(c) The provider should forward a letter to Medicaid justifying medical necessity prior to ordering the eyeglasses (reference Rule No. 560-X-17-.01(3).

(d) A response of either approval or denial will be returned to the provider. If approved, a prior authorization number will be assigned (reference Rule No.560-X-17-.01(3)

(e) If a patient desires frames or lenses other than those covered by Medicaid he/she must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for

retention with the patient's records: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

(2) Procurement.

At the option of the provider making the frame measurements, eyeglasses in conformance with Medicaid standards, may be procured from either the central Medicaid source or from any other source. Medicaid will pay no more than the contract price charged by the central source.

(3) Standards and Price of Frames.

(a) A list of authorized frames and contract prices is available in the Alabama Medicaid Provider Manual.

(b) The authorized frames, or frames of equal quality, will be provided for Medicaid recipients at the contract prices shown on the list. (Under normal circumstances the date of service for eyeglasses will be the same as the date of examination.)

(c) Patients having old frames, which meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements may have new lenses installed in lieu of being issued new eyeglasses. Medicaid will pay for the lenses only. The following statement should be documented in the recipient's record: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

(d) Services provided under this sub-paragraph are subject to the program benefit limitations.

(4) Lenses.

(a) Lens specifications are authorized at the specified contract price.

(b) Lenses will be of clear glass, plastic, or polycarbonate unless prior authorized by Medicaid because of unusual conditions, as indicated in Rule 560-X-17-.01(3). All lenses will meet FDS impact-resistant regulations.

(c) Spherical lenses must be at least a plus or minus .50 diopters; the minimum initial correction for astigmatism only (no other error) is .50 diopters.

(5) Services.

Services reimbursed for eyeglass procurement are: eye examination, including refraction; filling the lens prescription; supplying the frame; and frame fitting, including frame service, verification, and subsequent service.

Author: Elizabeth Huckabee, Program Manager; Physician and EPSDT Unit
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. §§ 435.520(3), 441.30(a)(b); State Plan, Attachment 3.1-A, page 5.12c.
History: Rule effective October 1, 1982. **Amended:** effective June 8, 1985. **Emergency rule:** effective December 1, 1986. **Amended:** effective March 12, 1987; January 13, 1988; March 13, 1993. **Amended:** Filed January 18, 2012; effective February 22, 2012. **Emergency rule:** filed and effective June 1, 2012. **Amended:** Filed July 12, 2012; effective August 17, 2012. **Emergency Rule:** Filed and effective November 1, 2012. **Emergency Rule:** filed and effective March 1, 2013. **Amended:** Filed May 9, 2013; effective June 13, 2013. **Amended:** Filed June 21, 2021; Effective August 14, 2021

Rule No. 560-X-17-.05 Billing Procedures

(1) All claims for payment of services rendered, filed by ophthalmologists, optometrists, and opticians are to be billed on appropriate form provided by the fiscal agent.

(2) Claims are to be forwarded directly to the Medicaid fiscal agent for payment within one year of the date of service. The Medicaid Provider Manual contains information on claims processing.

(3) A claim for payment may be submitted for a cancelled order.

(4) Eye Examination Only.

(a) The claim should specify "Complete Eye Examinations and Refraction."

(b) If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code. This claim should be sent directly to the Medicaid fiscal agent.

(5) Medical Condition and Treatment. The claim should be sent directly to the Medicaid fiscal agent.

(6) Eye examination (Including Refraction) and fitting (Including Frame Service, Verification, and Subsequent Service) all by the same provider when eyeglasses are procured from the central Medicaid source contractor:

(a) Claims are to be sent directly to the Medicaid fiscal agent.

(b) The claim will separately identify the extent of the examination, refraction and fitting. Lenses and frames are not to be billed by the practitioner.

(c) The Medicaid job order form reflecting all necessary prescription data including frame required will be forwarded to the central Medicaid source contractor to fill the prescription and return the eyeglasses to the examiner for delivery to the patient. Patient or Authorized Signature box will contain appropriate signature, or the statement "Signature on file."

(d) The central Medicaid source contractor will submit claims for payment to the fiscal agent.

(7) When eyeglasses are NOT procured from the Central Medicaid Source Contractor.

(a) The claim should separately specify the extent of the examination performed refraction, fitting, lenses, and frame.

(b) When Opticians provide eyeglasses the claim should only identify the fitting service, lenses and frame.

(c) The claim is sent directly to the fiscal agent. Reimbursement for lenses and frames will be at the central source contract prices.

(8) Fitting (Including Frame Service, Verification, and Subsequent Service) only, when eyeglasses are procured from the central Medicaid source contractor:

(a) The claims are to be sent for payment directly to the Medicaid fiscal agent.

(b) The claim will specify the fitting services only.

(9) Additional billing instructions will be published as the need arises by the Medicaid fiscal agent.

(10) An Alabama Medicaid provider may bill an Alabama Medicaid recipient when the recipient has exhausted all of his/her allowed Medicaid benefits for the calendar year, or when the service rendered by the provider is a non-covered benefit as outlined in the Alabama Medicaid Agency Administrative Code.

(a) Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are prohibited.

(11) Ophthalmologists and optometrists are required to collect and it is the Medicaid recipient's responsibility to pay the maximum designated copayment amount for each service rendered. This includes patients with Medicare.

(a) A provider agrees to accept as payment in full the amount paid by the State, plus any cost-sharing amount to be paid by the recipient, for covered items, and further agrees to make no additional charge(s) for covered items to the recipient, sponsor, or family of the recipient, except the appropriate allowable copayment amount.

Statutory Authority: State Plan, Attachment 4.18-a; Title XIX, Social Security Act; 42 C.F.R. §§ 401, et seq.; 447.15.
History: Rule effective October 1, 1982. **Amended:** effective July 9, 1984; June 8, 1985; January 13, 1988; March 13, 1993.

Rule No. 560-X-17-.06 RESERVED

Rule No. 560-X-17-.07 Special Situations

(1) Eye Care for Patients Eligible for Both Medicare and Medicaid. See the Medicaid Provider Manual for instructions in filing claims when the Medicaid patient is entitled to benefits covered by Medicare.

(2) If eyeglasses are prescribed under conditions not covered by Medicare, instructions and procedures appearing in other paragraphs of this chapter should be followed.

(3) Unusual Situations.

(a) Services for unusual situations may be provided when prior authorized. Full, written information justifying medical necessity must be sent to Medicaid prior to the service being rendered.

(b) Please refer to Rule No. 560-X-17-.01 (3) for prior authorization procedures.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. § 401, et seq.
History: Rule effective October 1, 1982. Amended: Effective January 13, 1988

Rule No. 560-X-17.-08 Assuring High Quality Care

Under the provisions of federal and state law, Medicaid must establish a mechanism to insure that all care is of good quality and that the service(s) for which billing was made conforms to that which was done. See Rule 560-X-2-.01 (1) for criteria.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. § 401, et seq.
History: Rule effective October 1, 1982.

Rule No. 560-X-17-.09 Copayment (Cost-Sharing)

(1) Ophthalmologists and optometrists are required to collect and it is the Medicaid recipient's responsibility to pay the designated copayment amount for each service rendered. This requirement includes patients with Medicare.

(2) Exceptions to the copayment requirement are listed in Rule No. 560-X-1-.25.

(3) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Author: Jacquelyn King, Program Manager; Medical Support
Statutory Authority: State Plan, Attachment 4.18-A; 42 C.F.R. §§ 447.15, 447.5, 447.55
History: Rule effective June 8, 1985.
Amended: Filed January 18, 2012; effective February 22, 2012.